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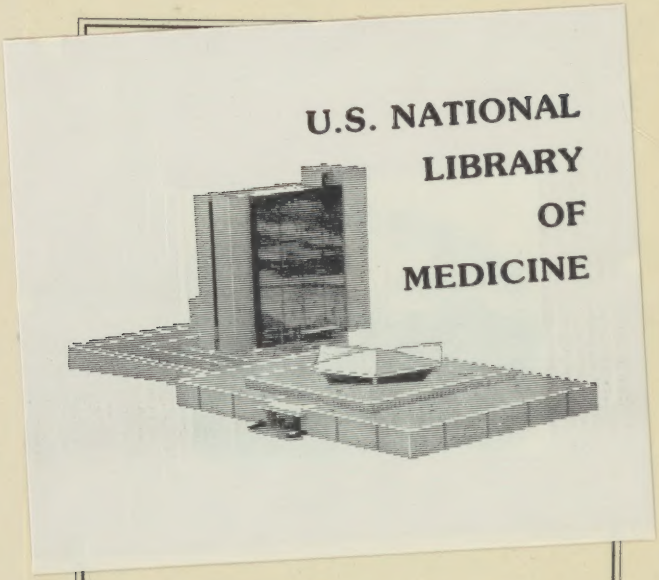
A report by a Commission appointed by
Honorable Thomas E. Dewey
Governor of the State of New York,
Pursuant to Section 8 of the Executive Law,
to investigate the management and affairs
of the Department of Mental Hygiene of the
State of New York,
and the institutions operated by it

1944



WASHINGTON, D.C.

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PREFACE

In March 1943, information was received by Governor Thomas E. Dewey of the existence of a rapidly spreading outbreak of amoebic dysentery at Creedmoor State Hospital located at Queens Village, New York, and of the failure of the Superintendent of the hospital to take steps recommended by local health authorities to stop its spread, protect the health of the patients, and prevent the extension of the disease to adjacent communities. Acting pursuant to Section 8 of the Executive Law, the Governor appointed a special Commissioner to make an investigation of the affairs and management of this hospital, and of the Department of Mental Hygiene, in so far as it related to the administration of this institution.

The results of that investigation were set forth in the report dated May 24, 1943, submitted by Archie O. Dawson, the Commissioner appointed by the Governor. During the investigation, Dr. William J. Tiffany who had been Commissioner of the Department of Mental Hygiene since 1937 resigned, and Dr. George W. Mills, Superintendent of Creedmoor State Hospital since 1935, was retired.

The report on that investigation indicated that the lax handling of the outbreak of amoebic dysentery was merely a symptom of administrative incapacity at the hospital. The investigation further showed, as set forth in the report, "an administrative breakdown in the Department as a whole, which warrants further study and investigation with a view toward the making of constructive recommendations relating to the entire Department."

Both the Governor and the Legislature determined that the conditions which were found to exist at the time of that investigation should not be allowed to continue. Up to this time, the Mental Hygiene Law had provided that the Commissioner of Mental Hygiene, appointed by the Governor, had to be a physician of at least ten years' experience, and "at least five years' actual experience in the care and treatment of persons afflicted with mental disease in an institution for their care and treatment." In its practical application, this meant that the Commissioner had been chosen from the Mental Hygiene system, and had been a former Superintendent of one of the State mental hospitals. The Legislature promptly adopted an amendment to the law, which was signed by the Governor, removing this restriction on the appointive power, in order that the Governor might appoint as Commissioner a man who was primarily an experienced hospital administrator. After an extensive survey of medical men with this type of experience in hospital administration, Governor Dewey appointed, on June 3, 1943, as his Commissioner of Mental Hygiene, Dr. Frederick MacCurdy, who had been for fifteen years Director of the Vanderbilt

Clinic of the Columbia Presbyterian Medical Center, and who was professor of Hospital Administration at the College of Physicians and Surgeons of Columbia University.

On May 26, 1943, Governor Dewey appointed a Commission of five members, also under Section 8 of the Executive Law, to make a complete and impartial survey of the operations of the entire Department of Mental Hygiene, and of the institutions which are administered by it.

The Governor, in appointing the Commission, stated that he had been "deeply disturbed by the evidence . . . of long-standing deterioration and breakdown in the Department of Mental Hygiene in the last few years." He directed the Commission "to examine the mental hospital system of this State, and to suggest methods for improving both the administration and the treatment of patients."

The Commission held its first meeting on June 5, 1943. In order that it might make its investigation with the aid and assistance of a staff of experts well qualified to appraise conditions in the past and to recommend practical improvements for the future, it retained a staff of persons who had long experience in various fields of hospital management.

The Commission appreciates the cooperation of the following institutions and departments which have made members of their staffs available for work on this survey:

Through the cooperation of The Rochester General Hospital, Dr. Christopher G. Parnall, Medical Director of that institution, was granted a six months' leave of absence to assume the post of Director of the survey. Dr. C. C. Burlingame, Director of The Institute of Living, one of the leading private institutions for the care of the mentally ill (formerly known as the Hartford Retreat), granted a three months' leave of absence to Dr. Percy L. Smith, a senior psychiatrist of his staff, to assist the Commission in making a survey of the medical and psychiatric care of patients in the State hospitals. The Commissioner of Health of the State of New York granted to Miss Mame T. Porter a leave of absence to supervise the survey of the dietary and nutritional problems in the institutions of the Department of Mental Hygiene. The State Department of Education loaned the services of Miss Josephine Valentine, R.N., to conduct the survey of the nursing care of patients and the State Charities Aid Association released Miss Winifred Arrington of its Social Service Staff to make the study of social service problems.

Certain members of the Commission and of its staff have visited each of the twenty-six institutions operated by the Department of Mental Hygiene. They have had long conferences with the new Commissioner, with the Superintendents of the various institutions and members of their staffs, as well as with representatives of the employees' association and of the Boards of Visitors. In every respect they have recived the utmost cooperation from Commissioner MacCurdy and the officials and employees of the Department.

In making its survey, the Commission has also sought the advice and assistance of leading members of the professions interested in the problems of the Department of Mental Hygiene. Outstanding members of the various professions accepted appointment to advisory committees appointed by the Commission, and gave freely of their time and experience in considering the problems presented to them. Members of these advisory committees visited certain of the institutions, worked with the staff members assigned to particular parts of the survey, conferred with the Chairman of the Commission, and gave their advice and judgment, based upon long professional experience, in appraising both the problems presented and the recommendations proposed to meet these problems. A list of the members of the advisory committees appears on page 122 of this report, and the Commission wishes to express its thanks and appreciation for the assistance they gave in the preparation of this report.

Since the Commission had utmost cooperation from the new Commissioner of Mental Hygiene, and since the Commission believed that conclusions from a survey of the nature suggested by the Governor could best be reached by a study of the problems by a staff of experts, it became unnecessary to have public hearings, but certain testimony was taken in private hearings.

The Commission adopted as its objective, at the first meeting, a policy of determining "what is best for the patient." In making the survey, the approach of the Commission and its staff was scientific and fact finding, rather than inquisitorial. The report does not deal so much with the individual institutions as with the problems common to all or many of them.

The report is not intended to be exhaustive and detailed. It is essentially a summary designed to serve as a practical guide in setting forth the principal problems affecting the Department of Mental Hygiene and to suggest the means for their solution.

No person who makes a study of this Department can fail to realize and appreciate the many fine points about many of the institutions or the conscientious performance of thousands of employees in carrying on the work of the institutions. The criticisms contained in this report should not lead to the conclusion that everything is bad in the Department. It is not. There is much of which to be proud and the fact that the emphasis in the report is upon conditions that needed correction should not keep us from realizing that on the whole the New York institutions, with all their faults, are among the best of the mental hospitals in the nation.

The defects were due primarily to the fact that the Department had not kept pace with the responsibilities placed upon it. Over the years a slowly creeping paralysis of bureaucratic inertia and lack of effective organization and executive direction from the top had been crippling the Department at the very time when its responsibilities were increasing. If it had not been for the energy and initiative displayed by the new Commissioner of Mental Hygiene, the present situation, with the dislocations due to the war, would have been more critical.

The report of the Commission shows certain underlying facts found by it which created this condition. Although the faults vary, back of all of them was this glaring lack of proper organization of the Department and its failure to secure persons of sufficient capacity for the important administrative and clinical positions in the Department and the institutions.

The Commission's recommendations for correction of the conditions found by it are contained in the report together with a summary of the corrective measures already taken by Commissioner MacCurdy or provided for in legislation introduced with the approval of the Commission.

INTRODUCTION

THE GROWTH OF THE NEW YORK STATE HOSPITAL SYSTEM

Relatively, as time is reckoned, the present rational attitude toward mental disorder is a recent development. "Lunatics" and "maniacs" were regarded formerly as dangerous members of society and were confined in penal institutions and given the general status of criminals. The mentally disturbed were frequently chained, restrained by harsh measures, or kept in solitary confinement. Gradually public officials, physicians, and the public in general came to realize that the mentally ill were not responsible for their condition and more humane measures for their care were provided. Even so, for many years the insane were committed to almshouses and local jails. Thus a stigma attached and, to a degree, still attaches to almost any type of mental illness. Progress has been slow but New York State has always been among the more progressive in the matter of public provision for the humane care of the mentally afflicted. From the opening of the first insane asylum at Utica just one hundred years ago, New York has shown an increasingly humane desire to provide adequate facilities for the care of the mentally ill, until today there are twenty civil mental hospitals caring for over 80,000 patients, together with six institutions for the mentally defective and epileptics, with over 18,000 patients. The institutions for the mentally ill are no longer known as "insane asylums." They have become "mental hospitals."

The passage of the State Care Act by the Legislature of 1890 marked the first recognition by a state government that the care of the indigent mentally ill was entirely a state rather than a local responsibility. Although in the early days of care of the mentally ill in State hospitals, or insane asylums as they were then termed, the institutions were under State control, the cost was a charge against the counties. Consequently many counties rather than pay for care in a State institution continued to retain patients in almshouses and even in jails.[1]

When the State in 1890 took on the entire responsibility for the care of the mentally ill, such responsibility included the cost of

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[1] The first State hospital was opened at Utica in 1843. The same buildings are still in use. In 1864 the Legislature ordered a state-wide inquiry into the care of the insane in the local poorhouses. Out of this grew the Willard Act of 1866 which provided a new hospital for the chronic insane, known as Willard State Hospital. The Act provided that all chronic insane should be removed from the county almshouses and from Utica and sent to Willard and that all acute cases were to be sent to Utica. By 1871 both of these institutions were so overcrowded that the Legislature passed a law enabling counties to receive exemptions from the Act and care for the chronic insane in their own county institutions which were usually adjacent to the poorhouses. The Act of 1890 abolished the distinction between the care of chronic cases and acute cases.

maintenance of patients in the institutions. A greatly increased demand resulted for the care of the mentally ill, to meet which there was a rapid expansion of the system. Until 1890 there were six State hospitals. In the decade following, seven more were established. Annual expenditures rose in the same period from $877,000 to $4,400,000. Since the turn of the century seven more mental institutions, aside from the State schools, including the State Psychiatric Institute and the Syracuse Psychopathic Hospital have been erected; and one, at Edgewood, Long Island, is in the course of completion.

In 1926, the State schools for mental defectives were transferred from the jurisdiction of the State Board of Charities to that of the State Department of Mental Hygiene. The first of the State schools was started on an experimental basis at Albany in 1851 and moved to Syracuse three years later. Admissions to the Syracuse State School are supposed to be limited to teachable mental defectives of school age. The Newark School was next in 1878, followed by Rome in 1894, Letchworth Village in 1911, and Wassaic in 1930. The Willowbrook State School, erected to relieve the congestion of the other schools, was turned over to the United States Army in 1942 for hospital purposes before it was occupied.

The Department of Mental Hygiene, as distinguished from the institutions under its control is a lineal descendant of the Lunacy Commission established by law in 1889. The Commission was composed of three members, a physician, a lawyer, and a representative of the public at large. Previously, responsibility for the supervision of the State mental hospitals, then six in number, had been lodged in the State Board of Charities. The creation of a Commission was strongly opposed by Superintendents at the time who felt that their prerogatives were being encroached upon unduly. In 1912, the Lunacy Commission became the State Hospital Commission, still with three members, and in 1927 the Department of Mental Hygiene was organized under a single Commissioner to whom was granted all the power previously exercised by the Commission.

From completely autonomous institutions under control of their separate Boards of Governors but with supervision from the State Board of Charities, the State mental hospitals have thus, by degrees, been consolidated under a single control. However, despite the obvious intention of the Legislature, the consolidation has not resulted in a smoothly operating system. Tradition dies hard, and even today the State hospital system in some respects is still an aggregation of individualistic if not individual institutions. For instance, a Superintendent of one institution cannot be transferred by the Commissioner to another institution without the consent of the Board of Visitors of the institution from which it is proposed to transfer him and transfers of personnel are seldom made, even when vacancies have existed for years. One hospital may be employing methods of treatment which have generally been accepted, while another may never have adopted them.

During the last twenty years the number of patients in the State

hospitals maintained by the Department of Mental Hygiene has increased by 100 per cent, and expenditures for maintenance have increased by approximately 150 per cent. The ratio of patients admitted per 100,000 population showed an increase of over 50 per cent during this period. This increase of patients is, therefore, accounted for only in part by an increase in population.

Investigation does not indicate that this increase in the patients in the State hospitals is attributable to an increase in insanity in the population but rather, that it is because of an increased acceptance of State hospitals as places in which persons with mental illness should be placed for care and treatment. The increase, also, to a substantial extent is the result of the placing in the State hospitals of arteriosclerotic and senile persons who previously had been taken care of either at home or in county institutions. This influx of arteriosclerotic and senile persons to the State hospitals became rapid during the days of the depression and has continued since that time. It is a problem peculiar to itself which is discussed in a later chapter in this report.

During the last twenty years only one new school for mental defectives was opened by the State. During this period of time the number of patients in the State schools has increased nearly three times and the expenditures for maintenance at approximately the same rate.

In 1942, Willowbrook State School with a rated capacity of 4,000 was completed to take care in part of the overcrowding which existed in the State schools. However, before it could be opened for patients it was turned over to the Federal Government at a rental of $1.00 per year to be used as an army hospital. It is now known as the Halloran General Hospital. It will be returned to the State when it is no longer needed by the Army.

The increase in population in the State schools is accounted for only in part by the increase in population during the past twenty years. The ratios of patients per 100,000 population was 58.5 in 1923 and 132.6 in 1942.

The following figures show the increase in the mental hospitals of the Department in the last twenty years (July 1, 1923–June 30, 1942):

	1923	1942*
Number of hospitals, including the Psychiatric Institute and Syracuse Psychopathic Hospital	13	21†
Resident patient population	38,002	73,120
Patients on parole and family care	3,300	9,933
Total patients under care	41,302	83,053
Ratio of patients under care per 100,000 population	403.6	668.9

* Figures have been used for the fiscal year ended June 30, 1942 in this table as well as in certain other places in this report by reason of the fact that the fiscal year which ended in 1943 was only a nine-month period and therefore, does not in many instances give a proper basis for comparison.

† Includes Edgewood State Hospital, not yet in operation.

Number of admissions and readmissions	8,772	17,611
Ratio of patients admitted per 100,000 population	81.1	128.7
Number of patients discharged as recovered	1,825	3,270
Ratio of recoveries per 100 admissions and readmissions	20.8	18.6
Expenditures for operation and maintenance	$11,954,658.79	$30,474,048.08
Capital additions and improvements	$2,183,991.26	$4,340,312.92

The following figures show the increase in the State schools for mental defectives in the last twenty years:

	1923	1942
Number of schools	4	6*
Total number of patients under care	6,368	18.144
Ratio of patients under care per 100,000 population	58.5	132.6
Number of patients admitted	995	1,534
Ratio of admissions per 100,000 population	9.2	11.3

Craig Colony for Epileptics was established in 1896 for persons afflicted with epilepsy. The increase in Craig Colony in twenty years is shown in the following figures:

	1923	1942
Total number of patients under care	1,573	2,514
Ratio of patients under care per 100,000 population	14.4	18.4
Number of patients admitted	233	221
Ratio of admissions per 100,000 population	2.2	1.6

The increase in expenditures from 1928 to 1942 for the State schools and Craig Colony is shown in the following:

	1928	1942
For operation and maintenance	$2,959,637.42	$6,601,472.22
For capital additions and improvements	$1,867,727.27	$3,923,482.94

* This includes New York State School for Mental Defectives, (Willowbrook) which is in use by the army at the present time.

CHAPTER I

PROFESSIONAL CARE OF PATIENTS

At the present time, because of war conditions, practically all of the institutions are understaffed. The shortage of physicians, nurses, and ward attendants is particularly acute in certain of the institutions.[1] It would not be fair, therefore, to judge the standard of professional care which existed prior to the war by that which exists today. The fact that the State hospitals and State schools are operating even as well as they are today, is a tribute to the loyal service of the physicians, nurses, and other employees who have voluntarily taken on increased duties and worked longer hours to handle the present problems of the institutions.

War problems, however, are not permanent problems and the war is not an excuse for certain conditions which have existed for many years. This Commission has, therefore, studied the problem of the professional care of the patients in these institutions, not with reference to the present alone but more particularly with reference to conditions before the war curtailed the professional staffs. Only by such a test can it be seen whether the Department has fully met the responsibilities imposed upon it. Steps which the new Commissioner is taking to meet, in part, the present emergency shortage of personnel, are discussed in the chapter on Personnel.

The hospital for the mentally ill properly has two functions: (1) a curative function to restore to sanity and good mental health, or at least to better mental health, as many of the patients as possible; (2) a custodial function to protect society from the harm or damage that may be done, if a person mentally ill were allowed at large in society.

Even the custodial function may be carried out in different ways. If the sole purpose were to protect society, the old system of dungeons and shackles would be sufficient. Modern society recognizes, however, that even patients confined for the welfare of society must be given sympathetic and humane treatment. The test should be not whether patients are kept in the institutions without escaping, but whether while in those institutions they are treated as mentally sick persons rather than as criminals.

The patients in mental institutions are often able to know and appreciate the difference between sympathetic and unsympathetic treatment. Life in a mental institution, even at its best, does not make them happy, but sympathetic care can make them happier than they otherwise would be. Only as long as they are treated as patients, rather than as prisoners, will they be enabled to live out their years in that greater comfort which society owes them.

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[1] The over-all shortages, as of October 1, 1943, were as follows:

Physicians	31%
Ward employees	32%
Other employees	17%

The shortage in each institution is shown on the chart on page 110 of this report.

The outstanding deficiency in the mental hospitals in New York State is that the Department of Mental Hygiene in past years has allowed them to become principally custodial institutions rather than hospitals in the true sense of the word. Progress in these institutions has not kept pace with that shown in general hospitals.

The war has accentuated some of the problems arising from inability to provide adequate curative care. The war has not caused them.

It cannot be expected that this condition is one that can be completely changed, for so long as there are mentally ill there will always be the problem of custodial care, and custodial care at its best has its limitations. Only so far as the State puts the emphasis on the therapeutic aspect, rather than the custodial aspect, will real progress be made.

To move in this direction is not easy. The easy path is that of custodial care. To move in the other direction requires initiative, imagination, leadership, and organization—qualities which have not been noteworthy in the Department of Mental Hygiene during the last decade.

The following conditions are found to have existed in these institutions, so far as the professional care of patients is concerned:

Medical and Psychiatric Care

When a patient is admitted to a hospital, he is given a physical examination. The inter-relationship of the physical and the mental is well known. Without an adequate physical examination on admission, the cure of the mental ills of the patient may be long delayed. However, in many of the institutions this physical examination on admission has been inadequately recorded. Particularly in the State schools and Craig Colony are the admission examinations cursory. Examinations of this type do not give an adequate picture of the individual's physical condition. For example, it has been obvious for a long time that no such physical study is complete without supplemental laboratory examinations and x-rays. Rarely in any of these institutions is a blood picture taken on admission and chest x-rays on admission have been started only in the present year.[2]

When a patient is first received he is placed in a Reception Building, where customarily living conditions are more pleasant than in the so-called Continued Treatment Wards. In the Reception Building, the patient usually sleeps in a single or double room and has more homelike surroundings. While in this building, an effort is made to diagnose his condition and determine the care or treatment needed. The reception units seem to work particularly well in most hospitals, for there the emphasis is upon diagnosis and treatment. These units are organized as hospitals and a substantial number of patients, after treatment for rela-

[2] All hospitals make a Wassermann test for syphilis; check on eye, ear, nose, and throat; and immunize the patients against typhoid fever, small-pox, and diphtheria. All female patients receive a gynecological examination. Routine dental examinations are made of all patients.

tively short periods of time in these units, are discharged. It is a striking commentary on the lack of statistical methods of this Department, however, that this Commission has been unable to ascertain what proportion of the patients discharged from the mental hospitals in a year had never progressed beyond the reception unit.

If a patient does not respond to a period of treatment in the reception unit, he is then transferred to a Continued Treatment Ward. Segregation in those wards is not by diagnosis but by the type of behavior of the patient. In this way acutely disturbed patients are separated from the mildly disturbed. These wards usually house approximately sixty patients who sleep in a single dormitory at night. The dormitories are connected with a room known as the Day-Room, furnished with heavy chairs, tables, and benches, off which room as a rule, is an open porch enclosed by heavy bars. In this day-room, the average patient spends the day hours unless he is assigned to work in some part of the institution or is sent to Occupational Therapy class.

The Commission has considered charges that patients in these Continued Treatment Wards are physically mistreated by employees and attendants. Undoubtedly some cases of this nature do occur, but the Commission believes that they are relatively rare and isolated cases. There has been no credible evidence of physical mistreatment of patients, except in rare cases and the Commission believes that the Superintendents of the hospitals are alert to the necessity of discovering and discharging employees responsible for such mistreatment.

The real problem is not one of active mistreatment of the patient as much as it is of the lack of adequate professional care of the patient. Proper psychiatric care requires active and not merely passive medical supervision. While there has been no budgetary ratio of physicians to patients in the mental institutions, this Commission is advised by the Department that a tentative ratio of one physician for each one hundred and fifty patients has been the goal of the Department. This ratio has never been achieved, the best ratio having been approximately one to one hundred and eighty.[3]

Even eliminating those physicians who are in executive positions and those who are charged with special functions, this ratio of physicians to patients would seem to have been sufficient if the psychiatrists could have given their time to the psychiatric treatment and care of the patients. The trouble has not been so much shortage of psychiatrists, as that these members of the staff have had too little time for education in and practice of psychiatry and very little supervision of their psychiatric work.

It is customary for one physician to be placed in charge of a building or a number of wards in a building. This member of the staff, as the system is at present organized, has charge of administrative matters with reference to the buildings or wards, takes

[3] The current ratio of physicians on duty in the institutions of the Department is one physician to approximately three hundred patients.

care of the physical ills of the patients, and is supposed also to attend to the psychiatric treatment of the patients. It is estimated by members of the Commission's staff who have visited the institutions, that from a quarter to a half of the time of the staff physicians is expended on the care and treatment of the purely physical ills of the patients.

The studies of this Commission lead it to the conclusion that two steps should be taken to enable these ward physicians to devote their time primarily to the psychiatric care of the patients in their charge.

In the first place, a better organization of the nursing care would take a considerable amount of administrative work from the shoulders of these physicians. This matter is discussed in the section on "Nursing Care of Patients."

In the second place, the care and treatment of the physical ills of the patients which now take a substantial amount of the time of the ward physicians, could be handled much better by a small resident staff of medical and surgical internes and residents supplemented by a visiting staff of outside physicians. To expect a physician who is primarily a psychiatrist, also to be an expert in the handling of fractures, treatment of conditions of the eye, ear, nose and throat, and in the treatment of the numerous other ills which befall patients in these hospitals, is fair neither to the physician nor to the patient.

The addition of such a resident staff of medical and surgical men would not mean an increase in the total number of physicians on the staff but rather a better organization of the staff since the number of physicians would, in the opinion of the present Commissioner, not need to be greater than the total number now provided for. The adoption of this proposal would mean that so far as the physical ills of the patients were concerned, the hospitals would operate on a basis similar to that of a general hospital. The work of the resident staff would be supplemented by a staff of visiting physicians in the various specialties of medical practice, who would have regular services in the hospitals as they now do in general practice. One institution which has already made considerable progress in this direction is Rockland State Hospital. In addition, it would be desirable to have physicians from the community who are specialists in the fields of neurology and psychiatry added to the regular visiting staff of all the institutions.

The results to be gained by the adoption of such a method of medical organization would be: (a) the ward physicians would be enabled to devote their attention primarily to the psychiatric care of patients; (b) the physical ills of the patients would be treated either by resident physicians, particularly qualified, or by specialists in active practice who would be conducting a regular service in the hospital; and (c) the entire institution would receive a stimulus because it would have, on its regular visiting staff, physicians in active practice who would thus bring the institution and its problems to the attention of the community and the local medical societies. Most of the hospitals today carry

in their reports lists of physicians as "Consulting Staffs," but these consultants come in only when they are called for special situations. They do not have a regular service in the hospital and are not substitutes for a regular visiting staff.

While it probably would be necessary in some cases to make some financial arrangements with outside physicians on the visiting staff, the expense of such payments would in the aggregate, be far less than the addition of competent specialists to the full-time resident staffs of the institutions; and the intangible benefits to be obtained from a visiting staff of outside physicians would be something which could not be obtained merely by adding members to the existing hospital staff.

When relieved of the duty of attending to the physical ills and with better organization of the nursing administration, the ward physician would have time to give that personal attention to the patients which is the prime requisite in the care and treatment of patients suffering from mental illness.

More time of the ward physicians for purely psychiatric care and treatment is not enough, however. There pervades many but not all, of the institutions, a listless attitude on the part of the ward physicians, and an intangible feeling that if the wards are clean and orderly their job is done. An active program of psychiatric care requires a different attitude than this.

Properly to analyze a mental condition and to help in curing it, it is necessary to understand the patient's background and that of his family and relatives, his personality, his adjustment to life from childhood, and the evaluation of his present symptoms. To promote a proper adjustment to life requires time and patience. It requires furnishing the patient in many cases with a course of activity which will develop his self-reliance and diminish his introspection. Lonely hours of idleness in wards accentuate rather than cure a mental condition. Too soon in such an environment, a patient becomes "institutionalized" and as a result, his mental condition deteriorates rather than improves. A program of affirmative psychiatric care requires a medical staff with an affirmative point of view.

Two factors seem to have been obstacles to the creation of such an attitude of mind on the part of the medical staff of this Department in the past:

(1) The Emphasis in all the Institutions Has Been on Administration, at the Expense of Clinical Medicine

A physician in the State hospital system should have an opportunity to advance to a top position on one of two lines, either (a) hospital administration in its various aspects, or (b) clinical medicine. The State hospitals properly should offer an opportunity for the physician specializing in psychiatry to make a life work of the medical care and treatment of the mentally ill. As the Department has been run in the past, however, a physician had to be both an administrator and a clinician; and advancement to the top positions in the Department was reserved for the psychiatrist who became an administrator.

In the larger hospitals provision has been made for several administrative assistants to the Superintendent. These share the administrative burden while the Clinical Director alone must assume the responsibility for the increased clinical work which must be carried on. No provision has been made for a sufficient number of Associate and Assistant Clinical Directors and as a result the position of Clinical Director has in many instances become an office desk job, leaving little time or opportunity for directing the care and treatment of patients.

The Clinical Director receives the same salary as an assistant to the Superintendent. To better his earnings, he must change over to administration and become an administrative Superintendent. The position of Superintendent carries the highest salary on the institutional payroll and hence it becomes the ambition of most of the members of the staff to leave their clinical duties and become executives as quickly as possible. Because of this, there are those with years of experience in pathology and with the highest clinical qualifications who have given up their chosen work and transferred to an administrative post in order to obtain advancement. Many promotions have been made directly from the clinical field to the superintendency.

As a result, in some institutions we have neither outstanding clinicians nor adequate administrative Superintendents. Different qualifications and different types of personality are needed for positions of such dissimilar natures. To make the institutions function as hospitals, the emphasis must be changed so that clinical medicine will rank equally important with hospital administration.

In the chapter on Departmental and Institutional Organization the Commission recommends a change in the hospital organization in order that the present condition will not continue, and so that a physician specializing in clinical medicine may thereafter advance to a post as Clinical Director in the institution more nearly comparable in compensation and emoluments with that of the administrative Superintendent, and so that there will be a differentiation in duties and responsibilities between the clinical staff and the medical administrative staff.

The Clinical Director in such an organizational set-up would supervise and direct the clinical work with the patients. He would have the responsibility of seeing that every patient's case was reviewed periodically and that the progress or retrogression of the patient was closely watched and studied. The ward physicians would be responsible to him. This would put the emphasis on the cure of the patients rather than merely on their custodial care.

(2) Appointment to Positions of Authority in the Institutions Has Been Limited to Physicians Who Have Made a Career of Being in the Institutions, with the Result That the Quality of Medical personnel has deteriorated

Under the Civil Service Law and Regulations medical positions, other than those of interne or assistant physician, have been filled

by Civil Service promotional examinations from those in a lower rank. As a result, any physician wishing to enter the New York State Hospital System could enter it only in the lower brackets of interne or assistant physician. The higher positions are then filled only by those promoted from lower ranks in the institutions.

The result has been that no new blood comes into the institutions from the outside except in the lowest rank. Those who enter the Department in this position as a rule fall into two groups: (a) those who desire a lifetime position of security and (b) those who are actively interested in the care of the mentally ill and wish to specialize in it. It is obvious that the physicians who hold most promise for the future are those in the second category. However, the physicians in this category are the very men who, as a rule, wish a variety of experience and who to a large extent, leave the State hospital system after a few years and go elsewhere to get a broader experience. It is just such men, or men of this type who have advanced in other institutions for the care of the mentally ill, who should have the opportunity to compete on even terms for positions of responsibility on the medical staff of the Department when a Civil Service examination is held. The present system allows for no such possibility and many of the able, progressive men are winnowed out of the system with no corresponding opportunity to draw in men of outstanding ability.

It is the opinion of the members of this Commission that although the Department now has more physicians on its staff than it had twenty years ago, the over-all quality of the physicians coming into the Department is relatively lower than it was at that time. Over half of the Superintendents stated that in their opinion one of the principal weaknesses in the Department is that it has not been attracting the best equipped types of physicians.[4] This matter is further discussed and recommendations are made with reference thereto, in the chapter on The Personnel of the Department.

The inertia which has resulted from the two factors above discussed is not easily measured. That such inertia has existed in the Department is, however, obvious. Two glaring examples are typical:

(a) Varying Use of Shock Therapy

The most important development in the treatment of mental illness in the last decade has been the development of shock therapy. When it first came into notice, arrangements were made by the New York State Hospital System in 1937 to have Dr. Manfred Sackel of Vienna, the leading authority on the subject, introduce the technique at Harlem Valley State Hospital. The then known treatment was insulin shock therapy. Arrangements were made for representatives of the different hospitals to be present and they

[4] According to the records of the Department, only seven out of twenty-six Superintendents are Diplomates of the American Board of Psychiatry and Neurology. Of those classed as First Assistant Physicians and as Clinical Directors, only twenty-five out of fifty-eight are so qualified; while in the senior assistant group only twenty-three out of one hundred eighty-five are Diplomates.

were instructed in its administration, technique, results, and dangers. Following this, the treatment was introduced in all except two hospitals of the New York State hospital system. It has since been widely used in other states and countries. Studies have been made both by the Psychiatric Institute and by the Temporary Commission on State Hospital Problems as to the results of shock therapy treatment, and those studies demonstrate its beneficial results in certain types of mental illness.[5]

A case study made by the Temporary Commission on State Mental Hospital Problems and published in the S.C.A.A. News of December 1942, shows that of 747 cases treated at Brooklyn State Hospital from January 1, 1937 to July 31, 1940 by the use of insulin shock therapy, 76 per cent were sufficiently improved to leave the institution and of those who recovered or were discharged from the institution, 53 per cent have never returned to it. The use of shock therapy is a recognized technique in the leading private institutions for the care of the mentally ill.

The second form of shock therapy to be introduced was metrazol. Electric shock therapy, the last to be introduced, has been continually used in many of the hospitals with good results.

Nevertheless, in spite of this record of early instruction in shock therapy and the good results which appear to come from it, we find the following: Only twelve out of the twenty hospitals are now regularly using insulin shock therapy. Only five are using metrazol regularly and two of the institutions have never used electric shock therapy. Binghamton, Kings Park, and Utica have used electric shock therapy only recently. One institution has never used any form of shock therapy.

In other words, a patient who lived in Syracuse, if he were taken into Syracuse Psychopathic Hospital and thereafter to Willard State Hospital, would never have had the advantage of insulin shock therapy, while the same patient, if he had been committed to Marcy State Hospital would have had the opportunity to receive the treatment.

Any such chaotic result cannot be entirely excused on the ground of lack of personnel, for some hospitals which have discontinued insulin shock therapy on this ground have no greater shortage of personnel than some which are continuing it. The fundamental reason was the inertia above described. Certain institutions were able and alert in clinical matters while others were not. There was no overall direction from the Department as a whole to bring up the standards of those institutions which were lagging behind.

(b) Tuberculosis

The incidence of tuberculosis in the State Mental Hospitals indicates a lack of medical care and supervision which is nothing less than shocking. In New York State during 1942, almost one

[5] Since the introduction of shock therapy into the Department of Mental Hygiene in 1937, there have been up to the present time fifty-three articles on shock therapy written by members of the staff of the Psychiatric Institute and forty-six articles written by members of the staffs of the various hospitals.

out of every ten deaths from tuberculosis occurred in State mental institutions. The tuberculosis death rate in these institutions for the three year period 1940–1942 was 611.5 per 100,000 population, compared with a death rate for the State as a whole of 45.7 or thirteen times as high as that of the general population.

A survey made of the incidence of tuberculosis among employees of the State mental institutions shows that it is almost twice that found among employees in general industrial occupations in New York State.[6] Between July 1, 1935 and October 15, 1942, the State Insurance Fund allotted more than $1,700,000 to meet the cost of medical care of and compensation for State employees who had developed tuberculosis in consequence of their employment in the hospitals of the Department of Mental Hygiene. The amount paid out by the State Insurance Fund represents only a part of the real cost of the ravages of a disease which experience shows can be largely minimized by appropriate measures of control. This cost does not include the direct and indirect cost of the disease among patients, nor the loss sustained as a result of illness and death not only by employees and patients but also by the population in general, in which contact infections have developed from the foci in the State institutions.

Not until 1941 were steps finally taken, in cooperation with the State Department of Health, to put on an organized program of control of the disease of tuberculosis in the mental hospitals. In that year a start was made and a survey made of all patients and employees to determine the extent of the existence of the disease. Analysis showed, in the twenty-three institutions first surveyed, that 4,273 patients or 5.2 per cent had clinically significant tuberculosis, requiring segregation and that an approximately equal number had lesions, apparently healed or not active. Among 14,228 employees, 156 or 1.1 per cent had clinically significant tuberculosis; while 359 or 2.5 per cent had apparently healed lesions.

A resurvey, now in progress, shows some improvement in the tuberculosis situation but a great deal must be done before a satisfactory control can be effected.

The almost casual way in which shock therapy has been employed and the ineffectual handling of the tuberculosis problem are tangible examples of inadequacy of medical care in the State mental institutions. They may be regarded as symptoms of a deep seated defect and justify the conclusion that the less tangible medical and psychiatric problems are, likewise, ineffectually dealt with when viewed from the standpoint of a progressive and scientific application of medical knowledge.

Nursing Care of Patients

Visits to many wards in many of the hospitals revealed huge, overcrowded, dreary units with masses of patients, some in bed receiving a minimum of nursing care, others up and, except as they

[6] The Commission has relied in this part of the report on an able survey recently completed on "Tuberculosis in State Mental Hospitals" by Dr. Robert E. Plunkett of the New York State Department of Health.

were assigned to assist with the work of the institution, inactive for many hours of the day. The majority seemed apathetic, some restless, and many unhappy. The wards were usually clean and orderly.

All up-patients, except those who are so extremely disturbed that they have to be confined in single rooms and except "working patients" who are sent to other parts of the institution for regular work hours, spend the greater part of the day in the Day-Room. It is a common sight to see some thirty to ninety patients sitting in rows in such rooms or walking restlessly up and down without any supervised activity whatever. When the weather permits such patients are occasionally escorted out of doors, in many institutions only for a group walk in a two-by-two file. Even with the occasional movies, dances, and other entertainment conducted in the main recreation building, there remain many hours of every day when large numbers of patients sit or walk idly about in the Day-Room with nothing to do. Instances were observed in some semi-disturbed and epileptic wards where there were not even enough chairs or benches to seat all of the patients, so that many had to choose between standing or sitting on the floor.

Merely safe nursing care is not sufficient. Good nursing care requires active individual care which speeds recovery or improvement and which contributes to the comfort and happiness of the patient. The greatest obstacle to a realization of such results in the present situation is the "mass treatment" of patients characteristic of the institutions.

While a certain amount of "mass treatment" must always be expected, nevertheless such treatment falls far short of what properly should be the objective. In a previous section of this chapter it has been pointed out that poor organization of the nursing care results frequently in a great burden of administrative work falling upon the ward physicians.

The present unsatisfactory situation with respect to nursing care in the State mental institutions results from a number of factors, other than an over-all one-third shortage in personnel incident to the war. The principal factors are: (1) inferior nursing procedures and facilities; (2) inadequate organization and supervision of the nursing and ward personnel; (3) inadequate ratio of registered nurses in the ward personnel; (4) inadequate quality of attendant personnel.

(1) Nursing Procedures and Facilities

Nursing techniques are unstandardized and often poor. Many of the supervisory nursing personnel either are not well taught or have grown careless in their nursing procedures or are too occupied with other matters or are generally overworked. The majority of the supervisory positions are held by graduates of the schools within the Department, yet the principals state that students complain of being unable to carry out on the wards the nursing procedures they have been taught in the classroom.

Well conducted hospitals have found standardized ward manuals of nursing procedures essential to the maintenance of good nursing practice. Such manuals are nonexistent in most of the mental hospitals.

Satisfactory facilities for maintaining an infectious precaution technique for the occasional infectious case which develops, are not to be found in a number of the institutions visited. Makeshift methods, some of doubtful value, are resorted to, such as merely screening the patient in an open ward and using hand solutions in lieu of thorough hand cleansing. In the majority of wards the beds are so close together that communication of upper respiratory infections seems to be inevitable.

Habit training for permanently institutionalized patients seemed conspicuously absent, particularly with the present shortage of personnel. The result is retarded recovery of some patients and excessive untidiness and accelerated deterioration of others. How one evil may intensify another is illustrated if one considers the relation between habit training for untidy patients and the problem of laundry supplies required when such training is neglected.

The nursing service or utility rooms are generally badly located and inadequately equipped. Facilities for sterilization and storage of ward equipment and supplies are often extremely meager.

(2) Organization and Supervision of the Ward Personnel

Throughout the State institutions there has been a divided responsibility for the nursing care of patients. The director was the principal of the School of Nursing in each of eighteen of the twenty-six hospitals and State schools. Although she may have been held responsible for the nursing, she had little or no authority over the nurses and attendants. As nursing is one of the most important functions in the care of the mentally ill, it would seem that responsibility and corresponding authority for this function should be centered in a single head.

In addition to such a Chief Supervising Nurse there should be, however, a sufficient number of competent nursing supervisors to maintain at all times a close check on the work of the ward personnel. No institution was found to have a general evening or night nurse supervisor. In only one of the thirteen institutions surveyed from a nursing standpoint were there three supervisors in each building or division, one for each eight hour period of the twenty-four hour day.

(3) Inadequate Ratio of Registered Nurses in the Ward Personnel

Because of war conditions most of the institutions have not been able to secure the personnel provided for in the budget. It is only by the service of those nurses and attendants who have stayed with the institutions and worked more intensively for longer hours that many of the institutions have been able to keep in operation at all. However, since it may be expected that this condition may correct itself at the conclusion of the war, the pertinent question is

whether the personnel for which the Department has asked in the past is sufficient to provide adequate nursing care for patients.

The Department of Mental Hygiene in establishing its budgets has apparently proceeded upon the basis of allowing the following ratios of ward personnel to patients:

Brooklyn State Hospital	1 to 5.5
Other Mental Hospitals	1 to 6.75
Craig Colony (for epileptics)	1 to 13

These ratios include both registered nurses and attendants but they do not represent the number of nurses or attendants on duty at any one time. When allowing for three eight hour shifts, days off, sick leave, and vacations, the ratio for nurses and ward personnel would mean that at the best there would be on duty at any one time only one nurse or attendant for approximately every thirty patients.

In order to arrive at some approximate estimate of adequate nursing service and of numbers of ward personnel and further to discover deficiencies, if any, this Commission secured the services of Elizabeth Bixler, R.N., to make a survey of the adequacy of nursing personnel in a typical State hospital. Miss Bixler is the Director of Nursing in Norwich State Hospital, Norwich, Connecticut and Dean-elect of the Yale University School of Nursing. She has had extensive experience both in private and State mental hospitals. Rockland State Hospital was selected as typical and her findings indicate what the nursing situation is generally throughout the State hospitals.

From this survey it was found that while the number of nurses and ward attendants on duty was inadequate at the time because of war shortages, the total number provided for would have been sufficient had there been a proper proportion of registered nurses to other ward personnel.

The following table shows a comparison of the number of nurses and ward personnel required for good nursing care, allowed in the appropriation, and at present employed.

	Number required for good nursing care	Quota allowed	On duty now
Supervisors	42	15	14
Charge Nurses	87	62	47
Staff Nurses	85	42	7
Practical Nurses	87	0	0
Attendants	578	749	444
Clerical Ward Aides	14	0	0
Total	893	868	512

The foregoing figures indicate that as far as the total number of nurses and ward personnel is concerned the quota allowed is only 2.9 per cent short of what might be regarded as an adequate number. The ratio of allowed ward personnel to patients is 1 to 6.6.

Even though the full quota were employed, nursing care would be inadequate, as there would be a disproportionate number of registered supervising and staff nurses. An adequate nursing staff

would require that approximately 24 per cent of the ward personnel be registered nurses, whereas the quota allowed this hospital calls for only 13.7 per cent of the ward personnel. Of the nursing personnel now on duty, registered nurses represent 7.8 per cent of the total quota and 13.2 per cent of the total ward personnel employed at present.

Commissioner MacCurdy is conducting a study of adequacy of nursing service in several of the other State hospitals in an attempt also to formulate a standard by which to measure the adequacy of the nursing service.

If the nursing situation at Rockland is to be considered typical of the State hospitals, granting that there would be varying factors affecting the adequacy of nursing in the different hospitals, it would appear that a total quota of nursing personnel on a basis of 1 to 6.75 patients would be sufficient to obtain good nursing care, provided, however, that approximately 24 per cent of such personnel consisted of registered nurses and provided that all of the ward personnel were assigned to the nursing care of patients and not used for non-nursing duties.

As of December 1, 1943, the total number of ward personnel authorized was 11,144 which represented a ratio of 1 nurse or attendant to each 6.4 patients. There was on this date a shortage of 33.2 per cent of ward personnel because of war conditions which reduced the ratio of those on duty to 1 to 9.7. Of the total authorized ward service personnel 1,574 or 14 per cent were registered nurses and of the total number of personnel actually on duty, 1,086 or 14.6 per cent were registered nurses. If the authorized quota had included 24 per cent of registered nurses, the total number in this category would have been 2,674 instead of 1,574.

The ratios established by the Department contemplated that all ward personnel would actually be doing ward work with the patients. This has not been the case, however, chiefly because of the widespread custom of "detailing" individuals from this group not only to fill gaps everywhere else in the institutions but also to fill positions not otherwise provided for. On the day of the visit to Willard State Hospital eleven attendants were "detailed" full time and thirteen part time (varying from two to eight hours daily) to such duties as central clothes rooms, telephone switchboards, garden or lawn work, distribution of mail or laundry, and ambulance or transfer duty. Three other ward attendants were doing full time occupational therapy work. Similar conditions exist in nearly all the hospitals. The custom of extracting someone from the ward personnel to fill every need elsewhere is a practice which cuts in seriously on the available ward personnel.

Another misuse of nursing service is the privilege accorded to officers of the institutions to demand an unlimited amount of special nursing care for members of their households. For example, in one institution, a staff member required the full time service of three professional nurses for several weeks to attend a child ill in his home with whooping cough. Since the average ratio of profes-

sional nurses to patients in all of the institutions is today approximately 1 to 75, the removal of three from any hospital service for a number of weeks makes a serious inroad upon the care of hospital patients.

Two hospitals, which were particularly studied with reference to the ward personnel actually doing ward duty, were Brooklyn State Hospital and St. Lawrence State Hospital, both of which had their complete quota of ward personnel. Although Brooklyn State Hospital had its full quota of nurses and attendants, a survey made on October 14, 1943 showed that there were actually on ward duty during that day approximately 21 per cent less than the quota contemplated, the difference representing those who were off duty for vacations, sick leaves, etc., and those who were "detailed" for duties elsewhere.

In St. Lawrence State Hospital, which also had no substantial shortage of ward personnel at the time of the survey, there were 176 attendants actually on duty in the wards during a twenty-four hour period out of a total of 270 attendants employed.

When we consider the hospitals which have a shortage of ward personnel resulting from war conditions, the situation is critical. In Willard State Hospital at the time of the survey there was a 38 per cent shortage of ward personnel. There are wards containing sixty or more patients in Willard State Hospital which for long hours in the night have no nurse or attendant present, since the person assigned has to supervise several such wards. In one building inspected by the Commission one attendant had the duty at night of supervising a ward of sixty patients on one floor and another ward of approximately the same size on another floor. When he left the first ward he locked the door and went downstairs and unlocked the door on the lower ward. During the time he was in the lower ward there was no person supervising or in charge of the sixty mentally ill patients in the upper ward who were locked in a room with no nurse or attendant present at all. This situation can be multiplied many times over. One ward in the hospital containing suicidal patients is unattended during certain hours of the night because the attendant is required to leave this ward and attend to two other wards.

The references to Brooklyn State Hospital, St. Lawrence State Hospital, and Willard State Hospital are not made as illustrative of conditions peculiar to those institutions but rather as typical of the two types of institutions, i.e., those which have their full quota of ward personnel and those which are suffering from a severe shortage of ward personnel because of the war.

(4) Quality of the Attendant Personnel

It has never been possible to attract as many desirable people to attendant positions as have been needed and today, not only are there many vacancies and a rapid turnover, but the statements of the administrative officers indicate that quality has

steadily deteriorated with the increasing difficulties in filling vacancies during the war. The former requirement that the institutions employ attendants from a civil service list without an adequate trial period on the job accelerated the lowering of quality.

To secure persons of the type needed in these institutions it is necessary to change the status of the attendant position and give some opportunity to those who have the capacity for advancement. Only in this way will there be attracted to this service men and women who will be interested in their jobs and interested in progressing to positions of greater responsibility. Recommendations leading to this end are discussed in the chapter on The Personnel of the Department.

Dietetics and Nutrition

While the food served to patients has been sufficient in quantity, it has been decidedly inadequate in those elements which are necessary for a balanced diet and much of the nutritive value of the food served has been lost by improper and inefficient preparation. The reason for this condition was only in part the small per capita budget allowance for food. A more important reason was lack of proper supervision of food planning and preparation and lack of provision for trained dietitians. This function of supervision has been largely carried on by Head Cooks who may be experienced in the management of kitchens and the handling of kitchen help but who have had little if any training in food values or in scientific food preparation.

(1) Lack of Dietetic Supervision

In only five of twenty-one institutions inspected by the Commission's Adviser on Dietetic Problems was there a Dietitian in charge of food preparation and service. The result of this lack of supervision is clearly apparent. For example, there has been a failure properly to utilize fresh foods which were already being grown on the institutional farm or were then present in the storeroom. At the time of the inspection in one institution, canned vegetables and canned fruit were being served when fresh vegetables and fruit from the farm were available.

In most of the institutions, food was overcooked and prepared far in advance of the time at which it was to be served. In some institutions, the food was served long before the patients were ready to eat it, with the result that by the time the patients arrived in the dining rooms the food was cold. In other instances, food traveled long distances without suitable containers to keep it hot. High nutritional losses occur in food when it is prepared far in advance of cooking time, when overcooked, when improper methods of cooking are used, and when such food is held hot over long periods of time. For these reasons the food in most of the institutions has lost much of the original content of its vitamins, particularly those of the B-Complex and of Ascorbic Acid (Vitamin C).

With few exceptions, the institutional menus are high in carbohydrates, low in protein and calcium, and deficient in vitamins. Yet with the beef purchased on the hoof by the State, pork raised on the farms, with the possibility of abundance of fresh vegetables, milk, poultry, and eggs, a satisfactory diet, from the standpoint of adequate nutrition could readily be provided with proper dietetic supervision.

It is, of course, impossible at the present time to secure the services of a sufficient number of properly qualified dietitians to staff the culinary services of the institutions. This is because of the demands, both civil and military, for large numbers of additional trained personnel. That the army recognizes the need for competent dietitians in army hospitals is shown by the fact that the Officer Procurement Service has recently issued a call for one thousand additional trained dietitians, and the New York State Dietetic Association has sponsored a recruiting rally to enlist them.[7] Minimum requirements of the army for the grade of Dietitian are four years of college with a major in Home Economics followed by at least one year of interneship training in an accredited hospital.

Only two of the hospitals and two of the schools out of twenty-one had Dietitians with a background of four years' college preparation who were in charge of the food service. One school had a graduate of a two year course in charge, six hospitals had two year course graduates in charge of special diets only, while the remaining institutions had no Dietitians whatever. The situation regarding Dietitians is not the result of the war; it has existed for many years. Many of the Superintendents have recognized the need for Dietitians and have tried to get them. They have failed to do so because, in the past years, they had no support in the Department's central office.

There are from three to thirty-five kitchens in the institutions visited, with as many as forty-six dining rooms in one. Without some central dietary control it is impossible to know what food actually is being served to the patients, or to keep any check upon the method of preparation of the food. In two institutions visited on two separate days, large groups of patients who were supposed, under the published menu, to receive cereals for breakfast, were found by the Commissioners to be receiving only three slices of bread apiece and a cup of Postum or cup of coffee. In each of these institutions, the Superintendent expressed surprise when informed by the Commissioners of this fact. The Steward stated that supplies were available, but in neither of the institutions had there been any effort to supervise the food which was served or to find out whether the patients were getting what they were supposed to receive.

The present Commissioner is cognizant of the need for Dietitians in each of the institutions and is making an effort to secure them,

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[7] *New York Herald Tribune*, December 5, 1943.

knowing that it will be difficult at this time to inaugurate what is, in effect, a new project, when available personnel is so scarce.

Not alone are experienced and qualified Dietitians with appropriate experience needed in each institution, but there should be, in the Commissioner's office, a trained and experienced Nutritionist charged with the duty of inspecting the institutions, and making certain that they maintain adequate food allowances and proper standards in the preparation and in the service of the food. In the past there has been no such supervision. Allowance has been made for this position in the new budget for 1944–45.

(2) Adequacy of Budget Allowance for Food

The State of New York, in the twelve months' fiscal period ending June 30, 1942, expended over seven million dollars for food for institutions in this Department, exclusive of food produced on the institutions' farms.

Quality of food purchased for the institutions and raised on the farms is for the most part good and the State has maintained an inspection service for purchased meat, fruit, and vegetables which results in maintaining good initial quality.

A breakdown of the cost of food during this period including food raised on the farms, has been obtained by this Commission. It shows that the daily per capita cost of raw food for all employees and patients in the State schools was $.244 per individual or a cost per meal of $.081. It shows that the per capita cost of raw food for employees and patients in the State hospitals during this same period was $.26 per individual and $.086 per meal. When it is considered that the amount of raw food used for officers and employees of the institutions is substantially better and larger than the amount consumed by the patients, it is readily apparent that the cost of food consumed by patients is materially less than the figures given above.

The Department of Mental Hygiene, in its General Order Number 6, has provided over the years that the daily per capita allowance of food for officers, employees, and patients shall be as follows:

Meats	9 oz.
Farinaceous foods	13 oz.
Potatoes	10 oz.
Eggs	1 egg
Milk	1½ pints
Butter	2 oz.
Cheese	⅔ oz.
Sugar	2½ oz.
Tea	⅕ oz.
Coffee	1 oz.
Fruit	25 cents per week per person

It is to be noted that this daily ration allowance includes no provision for vegetables other than potatoes.

The patients in the hospitals have not been receiving, however, the food allowance called for by the order of the Department. A comparison between hospitals in the use of this ration allowance is of interest. Two items can be reasonably compared—milk and eggs.

The following tables show what the ration allowance called for in eight of the State Hospitals with reference to milk and eggs and the amount of the products that were actually available to the hospitals in the period July 1–September 30, 1943:

	Ration allowance per person per day	Produced on farm and purchased during July, August, Sept. per person per day	Per cent of ration available during July, August, Sept.
	MILK		
Binghamton	.75 qt.	.50 qt.	67%
Brooklyn	.75 qt.	.55 qt.	73%
Buffalo	.75 qt.	.50 qt.	67%
Central Islip	.75 qt.	.72 qt.	96%
Creedmoor	.75 qt.	.72 qt.	96%
Hudson River	.75 qt.	.26 qt.	35%
Middletown	.75 qt.	.63 qt.	85%
Marcy	.75 qt.	.57 qt.	76%
	EGGS		
Binghamton	1	.64	64%
Brooklyn	1	.69	69%
Buffalo	1	.59	59%
Central Islip	1	.83	83%
Creedmoor	1	.82	82%
Hudson River	1	.46	46%
Middletown	1	.69	69%
Marcy	1	.58	58%

Thus, Central Islip and Creedmoor obtained 96 per cent of the ration allowance for milk while Hudson River obtained 35 per cent. Again, Central Islip obtained 83 per cent of the ration for eggs while Hudson River obtained 46 per cent. Needless to say, conditions such as these lead to unbalanced and inadequate diets.

The Commission is advised that in the budget for the fiscal year beginning April 1, 1944 an appropriation has been made for food in the sum of $9,033,333, an increase of approximately 25 per cent over the budget appropriation for food for the twelve months period ending June 30, 1942, even though the number of patients in the hospitals and schools is now less than in that fiscal period.

(3) General

The farms operated by the institutions under the control of the Department produce annually products valued at over $1,000,000, but there is evidence to show that in many respects the farm production is not coordinated to the food needs of the institutions. It is supposed to be the duty of the person in charge of food service

in an institution to plan with the farm manager a schedule of production, so that there may be available the right foods at the right time. There is little indication that this is commonly done.

Bread, which forms a considerable part of the diet in the institutions and appears frequently to be substituted for other articles on the menu, is turned out by the bakeries in generous quantity. It looks and tastes good but lacks enrichment. Since it forms such a large part of the diet, its use results in a daily caloric intake for patients which is preponderately carbohydrate and practically vitamin and mineral free. Many states now require by law that all white bread be made of enriched flour and contain at least 3 per cent of dried milk in order to assure higher protein, mineral, and vitamin content, and no lower standard should be maintained in the State mental institutions.

Food waste varies greatly in the institutions. Waste is frequently caused by lack of standardization of portions. Another factor causing waste is the failure to use standard recipes. Accurate measurement of ingredients assures uniformity of quality and cuts down extravagance and wastefulness in compounding diets.

In many of the institutions the kitchens are sadly in need of repairs and repainting. In others of the institutions the kitchens are without screens, with the result that flies are very much in evidence in the food preparation rooms throughout the summer months.

It is probable that for a long time to come most of the work in the kitchens and dining rooms will have to be done by patients acting under the supervision of trained attendants. The use of patients' labor in these capacities is perhaps not desirable, but in view of the shortage of available manpower cannot be avoided. It is a condition which can have bad results or good results, depending upon the adequacy of the supervision. In many respects, the use of patient labor in food preparation has a therapeutic value for the patients who are so employed. However, it is particularly necessary under those conditions to make certain that a careful check be kept on the sanitary facilities in the kitchens. This check has not been kept in the past. It would seem desirable that arrangements be made for a physical examination of every patient working in the kitchens or dining rooms, and that sinks be installed in each of the kitchens in such positions that all patients and employees would be compelled to wash their hands whenever they entered the kitchen. The training of patients and employees too, in rules of good hygiene, is important.

Correction of the physical conditions should be a primary objective in any plan for the repair of the institutions. However, the fundamental problem in this branch of the institutions, as in so many others, has been a failure on the part of the Department in past years to provide an adequate staff of trained personnel at the top to direct the food preparation.

Psychiatric Social Service

The logical future trend of the treatment of the mentally ill lies in emphasis on prevention and cure rather than on custodial care. If future needs are to be met, it will require a change not only in method but also in thinking. Attention to the individual patient must be intensified, supplanting mass methods as far as possible. Institutional care should be less and less necessary as an adequate program of prevention and extramural treatment is developed to augment it. Such a program involves continued psychiatric treatment of the patient and, in order to make it most effective the psychiatrist must know that the effect of his treatment is not nullified by social and economic conditions which prevent the patient's adjustment to life in the community.

To assist the physician in maintaining supervision of the patient in the institution but more particularly in the community, social workers especially trained in psychiatry should be available in sufficient numbers to assure unhurried, thorough assistance to the patient and his family in meeting the problems he faces in adjusting himself to independent living.

Good psychiatric social work is essential to the process of successfully paroling and discharging patients. It is not sufficient merely to treat and train the patient in the hospital. The ultimate objective should be to help him so completely that he can be released from the hospital and stay released. Successful parole or discharge requires consideration not alone of the patient but also of the social and economic environment to which he is returning. Too often on discharge the patient goes back to precisely the same family, business, or neighborhood problems which were responsible for his breakdown.

It is necessary, therefore, before a patient is paroled or discharged that investigation be made of the environment in which he is going to live. The family needs preparation for understanding him, or if he has no family, time must be taken to find a home in which he will be not only tolerated but accepted. Arrangements must be made, if possible, to keep him self-supporting. To parole patients without this kind of planning is to invite trouble rather than to avert it.

In the same way, after the patient is returned to the community, some follow-up is necessary to help him remain adjusted. This follow-up, among other things, makes it possible to detect any recurrence of old symptoms and in many cases enables the social worker to handle some of the more acute problems that arise within the household and so obviate the need for readmitting the patient to the hospital. To parole a patient and then be unable to help him through his emergencies is fair neither to him, the hospital, nor the community. In pre-parole investigation and post-parole follow-up the social worker should be an aid to the physician. She should be his arm reaching out into the community.

Two excellent studies of the adequacy of social service in the

State hospitals have been prepared under the auspices of the Temporary Commission on State Hospital Problems. They are:

"Study of Social Service to Parole Patients from Rockland State Hospital" by Edith Holloway, dated July 8, 1942.

"Study of Social Service to State Hospital Patients paroled in New York City" by Sue H. Mason, dated October 1942.

This Commission has not duplicated these studies. This Commission, however, has acquainted itself in some detail with the social service program of certain hospitals other than those intensively studied by the Temporary Commission and this survey indicates that certain of the conclusions reported in the above named studies are applicable throughout the State.

Miss Mason's study of social service activity with patients paroled into New York City shows that on February 1, 1942, the average case-load per worker was 117.3, while the average number of cases actually dealt with per worker was only 69. A considerable number of paroled patients were receiving no follow-up from social service at all.

A detailed case study of 100 patients on parole from Rockland State Hospital was made by Miss Holloway. She found that of these 100 patients on October 1, 1941, 46 needed chiefly follow-up visits and that only 25 patients or 54 per cent actually received this service. She also found that 50 patients needed additional rehabilitative services but that only 10 patients or 20 per cent actually received the help they needed. In other words, the social service staff has been able to ring the door bells of only about half the group for whom follow-up might have sufficed and has worked individually with only a fifth of those who, with more personal attention, might have been really helped to stay in the community.

Any reorganization of psychiatric social work in the Department should take into account the following rather obvious necessities:

1. Too large a case-load makes effective work impossible. As of November 1, 1943, the total number of cases assigned to social service in the Department was 14,616. There were on that date positions for 151 social workers of whom 136 were employed and working. This gives a case-load of 97 patients per authorized social worker and a case-load of 108 per social worker employed. Actually the 136 social workers were able to handle only 8,386 cases, or an average of approximately 62 cases per social worker. At a caseload of 60, it would have taken 92 social workers in addition to the 151 to cover adequately the 14,616 assigned cases. This is not the whole story. Of these 14,616 cases only 1,622 were cases living in the institutions. The balance were cases on parole, in family care, and in the community. There are no figures available to show how many patients living in the institutions need social service, but it may fairly be estimated that there are at least 60 potential cases in each 1,500 patients living in the institutions.

Other agencies of the Government have found that a smaller case-load than that in this Department is essential to effective work. For the Division of Parole of the Department of Correction, the law provides, for example, that there shall be one parole officer to each 75 cases. For the Home Relief Division of the Department of Welfare in New York City the case worker averages approximately 65 cases. Much more intensive work is needed from a psychiatric social worker than from either of these other groups and a case-load of more than 60 per worker imposes a responsibility which cannot be met adequately. Steps should be taken to provide at least one psychiatric social worker for every 60 patients on parole, in family care, and for cases referred through the clinics and one psychiatric social worker for each 1,500 patients living in the institutions. At these ratios there are now needed 211 social workers for those on parole, in family care and referred through the clinics and 60 more for patients living in the institutions. In other words, 271 social workers are now needed and positions exist for only 151 and not all of these positions can be filled.

It may be pointed out that if a social worker is responsible merely for keeping five patients out of the hospital for a twelve months' period, she has saved the State the equivalent of her salary. Adequate social service follow-up would be an economy rather than an additional expense.

2. Social workers in the institutions should not be used for functions that do not belong in their field. At the present time the Commission finds psychiatric social workers assigned to all manner of miscellaneous duties. They are taking visitors around the institutions, acting as chauffeur and escort for patients going to and from the hospitals for medical care or for readmission or parole, transporting medical specimens to laboratories, securing autopsy permits, arranging for State burials, disposing of patient's possessions and effects, and making psychometric tests.

3. Under present arrangements social workers supervising paroled patients do this from their respective hospitals regardless of the distance of the hospital from the residence of the patient. Workers from several different hospitals are, therefore, traveling from distant hospitals into the same territory. This is most particularly apparent in New York City. There, social workers from ten State Hospitals converge upon a single small area, traveling distances of from two to eighty miles one way from their several institutions and pursuing one another at times to the same block, even to the same house, to contact their respective patients. Because of sheer lack of organization, a dozen workers have been treading on one another's heels, spending energy and dollars, crossing and recrossing one another's paths through certain hours of the day, and then scattering to their hospitals at night. In a number of cases at

least a third of their time is spent traveling to and from their hospitals. Plans are now being developed by Commissioner MacCurdy to establish a parole centre in New York City which will enable a group of social workers operating from one central location to cover work with patients from ten hospitals around the Metropolitan area. This should permit the social work program to be divided intelligently on geographical lines, but preserving the institution-patient relationship, and at the same time conserving time, funds and energy. A corresponding plan for other districts of the State seems desirable in order to avoid useless travel. If the State is permitting its workers to spend large parts of their day in travel and so paying them merely to keep in motion, valuable opportunities for closer follow-up of patients are being thrown away.

Occupational Therapy

Occupational therapy is a useful adjunct in psychiatric care both for the custodial and the potentially curable types of patients. For the former, it provides a means of reconciling them to the institutional life; for the latter, it provides a step toward resocialization.

The current budget allows 237 occupational therapists, aides, and instructors for the twenty hospitals in the Department. This is approximately one occupational therapy worker for each 304 patients. Attached to the Commissioner's office there is also a Director of the Bureau of Occupational Therapy and a Supervisor of Physical Training.

The Commission has considered the efficacy of the occupational therapy program as it has been conducted in the past from two standpoints: (1) adequacy of personnel and (2) adequacy of the program.

(1) *Adequacy of Personnel.* It is the estimate of Commissioner MacCurdy that approximately 60 per cent to 70 per cent of the patients in all institutions should have some form of occupational therapy, but that at the present time only one-half of those who should be receiving this training are able to obtain it. To carry out fully an effective program in the institutions would require doubling the number of occupational therapists.

(2) *Adequacy of the Program.* Many of the departments of occupational therapy seem to be well run when looked at as units within themselves. A proper organization of this work, however, would require that it be coordinated directly with the work of the Clinical Director with emphasis placed upon furnishing occupational therapy for more patients and less emphasis upon the nature of the products made by the patients. To treat occupational therapy as a department by itself in the institution disregards the true objective of the program.

Great pride is taken by the occupational therapists in the objects made by patients under their direction. These objects are sold by

the hospital and the proceeds used to replace materials needed by the occupational therapy classes. The result seems to have been that not infrequently the occupational therapists have unduly accented the production part of the program at the expense of the therapeutic side. In many instances the occupational therapists have complained to members of the Commission and staff that the parole of patients has deprived them of good workers and therefore, they have not been able to turn out as good products as they had in past years and this despite the fact that the parole of a patient is the true objective at which they should be aiming. The test of an occupational therapy department should not be how many satisfactory articles are made, but rather how many patients have been helped on the road to recovery.

From this standpoint it is unfortunate that the products manufactured by the patients are sold by the hospital. It would seem to be therapeutically more desirable if the products made by them were to become their own property and if the proceeds from their sale were to go to those patients who made them or if, on the other hand, the objects were given to their relatives or friends. This would create a stimulus for activity which cannot be obtained when the products are sold for the general benefit of an occupational therapy fund.

Another way of disposing of the products of occupational therapy would be to utilize them in brightening up the appearance of the wards. In a few instances patients have been given the opportunity to make articles such as window hangings and furniture covers for their own quarters. Their interest in so doing has been notable and their pride in having something tangible to which they have contributed their effort and skill is manifest.

A proper coordination of the work of the occupational therapists with that of the psychiatric physician would also require that the occupational therapy department follow up the cases of the patients who work in the hospital. Patients who work in kitchens or dining rooms in the institution can be considered either as doing necessary labor or as engaged in a program of vocational readjustment. Too often the latter aspect of this work is ignored. Again, the necessity is apparent of regarding the institution as a whole rather than as composed of different segments and departments.

Summary

The conclusion is inescapable from any survey of this Department that the professional care of the patients has failed for years to come up to the standard that properly could be expected of it. Lethargic administration of the Department over the years has deadened initiative and created an inertia which it is hard to overcome in the present days of shortage of manpower.

The recommendations made in this Chapter and in Chapters VIII and IX of this Report would in the opinion of the Commission do much to correct the conditions which have been allowed to develop in this Department.

CHAPTER II

THE STATE SCHOOLS AND CRAIG COLONY

The State Schools

Under control of the Department there are five schools for mental defectives, the Syracuse State School established in 1851; Newark in 1878; Rome, 1894; Letchworth Village, 1911; and Wassaic, 1930. A new school, Willowbrook, located on Staten Island was completed but not occupied before it was turned over in 1942 to the United States Army.

The State schools show a greater degree of overcrowding than do the State hospitals, 20 per cent against 15 per cent. The figures, however, do not graphically present conditions as observed by actual inspection. To give only one example, at Letchworth Village space intended for treatment rooms was utilized as a ward for infants with thirty-two children in sixteen cribs, so crowded together that it was barely possible for the nurse to pass between them.

There are certain similarities between a State mental hospital and a school for mental defectives. Each has the function of custodial care and the responsibility of rehabilitation whenever possible of such of its patients as can maintain themselves as members of society.

On the other hand, there are marked differences. The patient with mental illness may be cured of his affliction; the one who is mentally defective can only be encouraged to make such effort as is within his mental capacity. The treatment of the one is primarily medical and psychiatric; of the other, training as far as his mentality will permit.

Two general classes of patients are found in the schools; those who are of sufficient intelligence to profit by instruction to a point where they can manage for themselves and those of such varying low grades of mentality that they must be cared for as long as they live. Custodial care is thus, relatively, a more acceptable objective in a school for the mentally defective than in a hospital for the mentally ill.

The following table gives a general picture of the distribution of various types of mental defectives under care in these institutions during the fiscal year ended June 30, 1942.

STATE SCHOOLS FOR MENTAL DEFECTIVES

STATISTICS FOR FISCAL YEAR ENDING JUNE 30, 1942

School	Total number under care	Number on parole	Number in colonies	Number in family care	Total number on parole, in colonies, and family care	Number of patients in institutions	Per cent on parole, in colonies, and family care	Grades of Defectives				
								Number of idiots	Number of imbeciles	Number of morons	Not mentally defective and unascertained	Per cent of high grades on parole
Letchworth Village	4,701	519	.....	207	726	3,975	15	708	2,149	1,474	370	22
Newark	3,178	546	182	225	953	2,225	30	419	1,260	1,291	208	24
Rome	3,950	412	965	...	1,377	2,573	35	483	1,751	1,700	16	18
Syracuse	1,350	386	388	...	774	576	57	10	96	1,244	...	30
Wassaic	4,965	373	25	166	564	4,401	11	713	2,090	1,780	382	13
Total	18,144	2,236	1,560	598	4,394	13,750	24	2,333	7,346	7,489	976	20

(a) Education in the State Schools

Since the mentally defective, even those of the highest grades, are capable only of limited academic attainment, their training requires teachers with specialized preparation. High grade defectives, given what academic education they can absorb, together with graded vocational training, can be made self-supporting.

For the lower grades of mental defectives, i.e., idiots and low grade imbeciles, continued custodial care is necessary. Those at the lower end of the scale are practically without mentality, helpless, and unteachable. Those with some glimmer of intelligence can, with habit training, become less burdensome and may be able to learn simple exercises such as music-rhythm, or if possessed of a somewhat more advanced intelligence, can do handiwork of varying quality.

When the Syracuse State School was opened, its purpose was to receive only teachable children of school age. Newark State School was designed for feeble-minded girls. Rome State School was established as a purely custodial institution and was first known as "The Rome State Custodial Asylum." Likewise, Letchworth Village which was opened in 1911, was established as "The Eastern New York Custodial Asylum."

Although the original intention was obviously to segregate the teachable mental defectives from those requiring only custodial care, today both teachable and custodial cases are found in all of the State schools. If it is desirable, as an educational policy, to segregate retarded children in special classes in the public schools, the question naturally arises whether the teachable mental defectives should not be placed in separate schools and removed from contact with the low grade imbeciles and idiots.

This Commission is of the opinion that teachable mentally defective children capable of rehabilitation should be segregated in separate schools in which the primary function is education and training rather than medical and psychiatric care. Patients sent to custodial institutions who are later found to be teachable and potentially able to return to community life should be transferred to schools specializing in education and rehabilitation for self-support. This was the original policy of the State.

In order to insure the most effective use of educational methods there should be on the Commissioner's staff an experienced educator who has specialized in the field of training of the mentally defective. It would be his function to coordinate and supervise the program of education in the State schools and advise the Commissioner regarding policies and methods relating to such program.

(b) Provision for Mentally Defective Infants

More adequate provision should also be made for mentally defective infants in certain of the State schools. While an opinion of the Attorney General can be construed to mean that the State does not assume responsibility for mental defectives under the age of five years, as a practical matter the responsibility has been assumed but without corresponding accomodations being made avail-

able. A mentally defective child under five, particularly if of low grade, can be harmful to and disruptive of normal family life and it is to the interest of the State, as well as to the family, to have such a child cared for in a suitable institution. If they are to be accepted however, adequate facilities must be provided for them.

(c) Colonies of the State Schools

By a colony is meant a relatively small supervised unit detached from but under control and direction of a parent institution. The colony serves two purposes: (1) a means of transition from institutional life to life in the community, and (2) a place for a modified type of custodial care for patients who, although able to adjust themselves with help to a semi-independent life, are incapable of living "on their own" in the community. The colony system has been highly successful as operated by three of the State schools.

The following table shows the number of colonies of the State schools and the distances from their parent institutions:

	100–200 miles	50–100 miles	20–50 miles	15–20 miles	10–15 miles	Under 10 miles	Total colonies
Letchworth Village	..	..	..	..	..	..	0
Wassaic	..	1	..	..	..	..	1
Newark	..	1	2	..	..	4	7
Syracuse	..	..	..	..	..	16	16
Rome	2	1	2	1	2	26	34
Total	2	3	4	1	2	46	58

Nineteen colonies are owned by the State, while 39 are rented. They are located from the Hudson River to Lake Erie.

From the foregoing table it is to be noted that of the 58 colonies, 9 are 20 miles or more from the parent school, one being 200 miles from the parent school. Such distant units are difficult to supervise and expensive to operate. They have been established over the years without sufficient thought being given to proper location. The present Commissioner has already started a plan for the relocation of distant colonies by transferring a colony of the Rome State School located in Syracuse to the nearby Syracuse State School. For effective control and adequate supervision, colonies should be located generally within a convenient radius of the schools to which they are attached. Distant colonies now operated should be relocated on sites within a short distance of parent institutions.

Some of the buildings housing colonies, particularly rented structures, are not adapted to their use. For instance, the Commission found one rented building in Syracuse occupied by a work colony of eighteen girls with a single bathroom and so overcrowded that three girls were sleeping in an unfinished attic. The colony system is of such value that the State should provide suitable quarters for the colony units. They should be such as to inspire a feeling of pride on the part of the children and to attract the best type of supervisors.

There are two types of colonies in the State schools: (1) school colonies and (2) work colonies. The former are for patients receiving instruction, usually the younger children, and for those able to live custodial lives but unable to progress to work colonies. The latter are for patients who show sufficient aptitude to give promise of ability to care for themselves after a period of supervised work and communal life.

Boys in the work colonies are usually sent out to be employed on neighboring farms while girls are sent to nearby homes for domestic service during the day, returning at night to the colonies. Funds earned by these children are placed in a colony account and are used with the approval of the Commissioner for the expenses of the colonies and school. The children receive weekly allowances and at one school personal savings accounts are added to monthly. As the earnings of the children are really a credit against a charge for maintenance, it is felt that the best interests of the State would be served by indicating this connection through a personal account for each child.

As the work colonies are self-supporting to a large extent and as overcrowding in the schools, especially at Letchworth Village, can be partly overcome by an extension of the colony system, such an extension should be planned wherever possible.

Craig Colony for Epileptics

This institution was opened in January 1896 for the care of epileptics. The purpose of the institution is "to secure the humane, curative, scientific, and economical care and treatment of epileptics, exclusive of insane epileptics" (Mental Hygiene Law, Sec. 150). Epileptics who are mentally incompetent but not insane are admitted to the institution. The provisions for commitment of incompetent epileptics are similar to those provided for the commitment of patients to State schools or hospitals. Of 166 patients admitted during the last fiscal period, 131 were mentally incompetent, i.e., morons, imbeciles, or idiots.

During the fiscal year ending March 31, 1943 the average daily population, excluding parolees, was 2,303. The certified capacity of the institution is 1,990. The percentage of overcrowding on October 1, 1943 was 11.6 per cent. The institution covers 2,108.5 acres and represents a capital investment by the State of $4,389,-199.14. A farm is maintained at the institution which has a dairy herd of 102 cows; farm products were raised in the last fiscal period to a total value of $97,049.46. The budget for the last fiscal period (nine months ending March 31, 1943) was $737,475.95.

The shortage of employees in this institution is one of the worst in the Department. As of October 1, 1943, this shortage was 32.7 per cent of the total positions allowed for this institution.

This institution seems to have been divided by its previous Superintendent into two classifications, one group for the care and

treatment of patients of approximate normal mentality and the other for the care and treatment of those whose mental incompetency was marked. For those in the first group the care and treatment seemed to be up to the standard maintained in other institutions. The patients live in cottages or houses which are clean and well cared for. They are allowed the freedom of the grounds; athletic and recreational facilities are provided. A school is maintained for children, attended by one hundred sixteen pupils and staffed by eight teachers assigned from the State Teachers College at Geneseo. Occupational therapy classes are also conducted.

When we turn to the care of the other group of patients, the deteriorated, conditions were found to have existed over the last five or six years that beggar description. A visit to the Onondaga Building and the Schuyler Building, where these patients are housed, revealed conditions not duplicated in any other institution in the Department.

The Schuyler Building was designed to house two hundred women. Over three hundred women have been crowded in there, all epileptics and all mentally incompetent. This building has a dormitory lined with beds and a Day-Room where the patients can spend their daytime hours. Patients are not allowed in the dormitory during the daytime unless they are bedridden. The Day-Room has only a few benches or chairs in it, so that for the majority of the three hundred women crowded in this building there is no place to sit during the daytime hours except on the floor. Women walk around and sit on the floor of the room during the day in various states of undress. Since there are only two hundred beds in the building and since there are over three hundred women housed there, it has been necessary to provide sleeping accommodations for the balance by laying over one hundred mattresses directly on the floor of the Day-Room when evening comes, and on these mattresses, laid side by side throughout the length and breadth of the room, one-third of the women spend their nights.

In the similar building for men, the so-called Onondaga Cottage, similar conditions exist. In this building over sixty men sleep each night on mattresses laid on the floor of the Day-Room. In this room itself, in daylight hours, nearly two hundred patients walk up and down with no place for most of them to sit except on the floor and nothing to keep them in the least occupied. In a corner closet are piled sixty mattresses foul with the smell of urine, waiting to be laid out in rows on the floor of the Day-Room when evening comes. In this building young boys are herded together with middle-aged and old men, all of them mental incompetents and some admittedly sexual perverts. Also it has been the practice of the institution occasionally to place other patients in this crowded room, not because of their degree of mental incompetency, but to punish them for disobedience or for attempting to run away from the institution.

The contrast between these crowded buildings and the cow

barn, where the dairy herd of the institution is kept, is marked. The cows are kept in clean spacious quarters, well provided with fodder, while certain of the wards of the State in this institution have lived and slept under conditions which members of the Commission felt could never have existed in a civilized community.

This is no new condition. It was admitted by the physician in charge that the same conditions have existed in these buildings for at least six or seven years and possibly for ten years. The present shortage of attendants has made the condition more critical but essentially conditions are the same in these buildings as they have been for a number of years. There has been no adequate explanation given as to why such conditions should have been allowed to exist either by the institution or the Department of Mental Hygiene over such a period of time. That they were allowed to exist seems to have been the result of:

(a) Inertia of the Management of the Institution

Other buildings in this institution have not been filled to capacity. One building, designed to house sixty patients, was completely empty for over a year. Some remodelling of the buildings and a shift of patients and personnel would have helped to some degree to correct the conditions which have been allowed to exist with reference to the deteriorated patients. Commissioner MacCurdy, upon his first visit to the institution, ordered immediate plans to be drawn up to this end so that the present facilities of the institution can be used to their best advantage. Some such steps could have been taken long ago by a vigorous administration of the colony.

(b) Lack of Attention by the Department to the Needs of the Institution

Proper inspection of the institution in the past would have revealed the conditions which this Commission finds to have existed over a number of years, and proper allocation of funds by the Department would have provided for the building or reconstruction of a building in the colony in such a way as to bring the standard of care for these patients up to at least that given patients in other institutions of the Department. The Acting Superintendent, who succeeded the former Superintendent who retired on October 1, 1943 after thirty-five years' service as Superintendent, stated, and the Commission thinks with justice, that the institution has been treated as a "step-child" of the Department for years past.

CHAPTER III

EDUCATION AND RESEARCH

The study of mental disease in all its aspects holds out a prospect for progress in medical science. Psychiatry must be dynamic, always seeking for causes, trying new methods, and alert to opportunities to spread knowledge. It is only in an atmosphere where teaching and learning flourish that the patient stands the best chance for recovery. The State hospital system offers a vast field of opportunity for education, a field that has been neglected to the detriment of patients, physicians, and the public alike. Nothing would contribute more to improved care than the creation of an atmosphere of education and research throughout the whole system. If well trained, imaginative, and intellectually active workers are needed, there is no better place to train them than in the State hospital system. That it has not been done to the extent possible does not mean that it cannot be done. What is needed is leadership and opportunity.

Medical Education

The opportunity of the mental institutions for medical education should be utilized both for undergraduate and graduate instruction. One of the essential factors in reducing the incidence of mental disorders is the early diagnosis and treatment of conditions which, if detected before they progress to serious stages, require no long period of hospitalization. The average medical practitioner has had little opportunity to learn even the elements of psychiatry. Courses in medical schools are usually sketchy and contact with patients afflicted with mental disorders is very limited. If good clinical work is to be done in the mental hospitals, the medical schools throughout the State in cooperation with these hospitals, should develop valuable courses of practical instruction in psychiatry for their students, providing not just casual "look—see" visits but actual experience with patients, the basis of all sound clinical training. Medical students would actually work in the wards, the laboratories, and the libraries. Thus, when the student becomes a practitioner he would have at least a groundwork of knowledge which would enable him more adequately to manage his patients who exhibit signs of mental breakdown.

Practically in all cases, before a medical graduate goes into independent practice or begins his preparation for a specialty, he serves a period of internship in a hospital. With the vast wealth in clinical material, with an expanded program of sound clinical teaching, and with the provision of adequate laboratory and research facilities, the State hospitals should be able to offer the most attractive opportunities for internship that the medical graduate could possibly find. The advantage to the hospital in being able to secure the best product of the medical schools ought

to be perfectly obvious. Opportunity for training in many branches of medicine can be offered, certainly in psychiatry but equally so in various specialties of medicine and surgery. Thus, the State would contribute to the better professional equipment of many physicians who would practice within its borders, some of whom would be attracted to the medical service of the hospitals in which they had trained.

However, in the education of physicians the State hospitals should not attempt to be self-sufficient. The medical staffs of the best general hospitals in the State are made up of outstanding practicing physicians who serve the poor without pay and whose chief compensation comes from association with others of their kind in a common effort constantly to extend the limits of scientific medicine. Visiting medical staffs similar to those of general hospitals should be assembled to serve the mental hospitals. This recommendation has been discussed in the chapter on Professional Care of Patients. Such visiting staffs would, as in the general hospitals, be teachers of the resident staff and help create an atmosphere of scientific medicine in which the entire staff would be inspired to do better work.

The interest in the advancement of medical science of a hospital medical staff embraces so many intangibles that it is difficult to appraise such interest, either quantitatively or qualitatively. A number of years ago, however, in searching for a measure which would be indicative of such interest, Dr. Henry Christian, then Professor of Medicine in the School of Medicine of Harvard University, proposed that the percentage of autopsies, more than any other one thing could be used as an index of the scientific interest of a hospital medical staff. The American Medical Association has adopted such an index and has set a minimum percentage of .15 of autopsies for any hospital before it could be approved as a place for the training of internes.

For the year 1942 the American Medical Association reports for hospitals approved for interneships and residencies an autopsy rate of 35.2 per cent while for registered hospitals not approved the autopsy rate is only 11.3. There were, in the same year, twenty-one hospitals with autopsy percentages of .70 or over.[1]

During the fiscal year ending June 30, 1942, there were 6,663 deaths of patients in the State hospitals with 1,851 autopsies or a percentage of 27.8 of autopsies. In the previous fiscal year there were 6,693 deaths with 1,877 autopsies or a percentage of autopsies of 28. In the 1942 year, the percentage of autopsies in the different hospitals varied from a low of 7.7 to a high of 48.3.

Since the percentage of autopsies is considered so important as an index of its scientific and teaching standards, a hospital should make every effort to utilize every death as a means of adding to medical knowledge. Both from the standpoint of the interest of

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[1] Journal of the American Medical Association, March 27, 1943.

the staff itself and from that of attracting the best type of young medical graduate, a hospital should strive constantly to improve its record in the percentage of autopsies performed. An average percentage of 50 is easily within the reach of the State mental hospitals and a goal of 75 per cent is not too high to expect to attain.

Laboratory facilities for research with adequate personnel are lacking in all of the State mental hospitals. Pathologists where they are present have usually had their training almost entirely within the State system and lack a diversified background of scientific training.

To combat ingrowing tendencies each institution should have a travel-study fund to enable members of the medical staff to attend important professional meetings and to visit centers where noteworthy medical work is being done, in order to study new methods which may be of interest and use in their own institutions.

Psychiatric Institute and Hospital

The State Psychiatric Institute, which was first known as the Pathological Institute, was established by the State Commission in Lunacy in 1895 and was located at No. 1 Madison Avenue, New York City. In 1901, the Institute was moved to Ward's Island. The cornerstone of the present building, housing the Psychiatric Institute, was laid December 17, 1927, and the building was formally dedicated December 3, 1929. This institution was specifically designed and equipped for the following purposes:

(1) To conduct special experimental and clinical investigations into the causes and treatment of mental disorders.

(2) To provide facilities for teaching psychiatry to medical students.

(3) To organize and present courses of postgraduate instruction to physicians in psychiatry and allied subjects, especially physicians connected with State institutions under the supervision of the Department of Mental Hygiene.

The Institute does not operate as a general reception or observation hospital and does not specialize in the emergency care of mental disorders.

This institution is well equipped and well staffed. At the close of the last fiscal year it had fifteen physicians and sixty-seven graduate nurses on its staff with a total personnel of two hundred and forty-two officers and employees. There were one hundred and fifty-five patients in the hospital at the end of the fiscal year. The State expended for the maintenance and operation of the institution during the nine months' period ending March 31, 1943, the sum of $417,083.06.

It is difficult, of course, to appraise the value and adequacy of scientific research such as has been conducted at the Institute but many excellent papers have come from work done by the Insti-

tute.[2] However, the Commission was struck by the lack of coordinated research at the Institute. While it is obvious that members of the staff of the Institute should be given an opportunity to do individual work in fields in which they are particularly interested, it would also seem desirable that there should be in progress one or two large coordinated investigations in some field of mental illness, including its related subjects, which would represent contributions from all members of the Institute's staff. In such studies the Director should play an active directing part.

While the first two purposes for which the Institute was organized seem to have been fulfilled in part at least, the third purpose seems never to have been carried into effect, except to a very limited extent. Physicians connected with the State hospitals have not had the postgraduate instruction or stimulus from the Institute which it properly could have provided. This has been partly the fault of the Institute and partly the fault of previous Commissioners of Mental Hygiene who failed so to coordinate the work of the Department as to make the Institute a dynamic teaching and research center for the institutions within the Department. The Institute has been run as a separate institution devoted to its own research and the teaching of medical students and has not been closely coordinated with either the work or the staff of the State hospitals. As a result, the State hospitals generally have a feeling that the Institute is separate and apart from them and not conversant with their problems and of little help in meeting them. This fact is recognized and regretted by the Director and the staff of the Institute. The Director has in the past tried to develop a program which would integrate generally the research and teaching of the Institute with that of the State hospitals but states that he has received no active support from previous Commissioners and many of the Superintendents.

To get full value for the Department from the Institute, the Institute should be not merely a separate research and teaching organization but also a research and teaching organization for the hospitals in the entire system. It should bear the same relationship to the hospitals that the General Staff School bears to the various units in the army during peace time. Its staff should not operate in cloistered seclusion but its influence should spread into the State hospitals and draw new personnel from them. While war conditions and shortage of personnel make impracticable any decided changes in policy at the present time, it is believed that a constructive program could be instituted by the Department which would bring about such changes as soon as conditions return to normal. With such objectives in mind it is recommended, when conditions do return to normal, that the Department and the Institute work out a program of coordinated liaison in the following manner:

(1) Members of the staff of the Institute should be sent for periods of time to various State hospitals to give lectures,

[2] Summaries of research work done at the Institute from 1930 to date have appeared in the Psychiatric Quarterly Supplement published by the Department in the issues of April 1940 and January 1943.

demonstrations, and instruction in advanced methods of treatment and diagnosis to the medical staff. The teaching program of the Institute would in this way be carried to the hospitals. There should be no reason for some State hospitals to state, as they do at present, that there is no member on their staff who has been thoroughly instructed in shock therapy or other advanced methods of treatment of the mentally ill.

(2) Arrangements should be made whereby younger physicians on the staff of the State hospitals would receive an opportunity from time to time to take a period for advanced study or do specialized research work at the Institute as members of its staff and without any loss of salary or seniority in their own institutions. Prior to the war, inter-hospital conferences with certain physicians from the upstate and downstate hospitals were held at periodic intervals but these conferences failed to meet the real needs of the situation for they were more in the nature of "refresher" courses than an opportunity for postgraduate study and research. It hardly needs to be pointed out that if younger physicians in the State hospitals had the opportunity during their career for a period of postgraduate research and study, it would provide a stimulus to more advanced thinking and therapies, the result of which would be incalculable to the State hospitals. At the present time, it is all too easy for a young physician in a State hospital to let his professional imagination grow dulled with the passage of years, his interest in research become stagnant, and to consider that which has been done in the past as sufficient for the present and the future. If the Institute were to afford to the more promising younger physicians from the State hospital system an opportunity for a period of residence and postgraduate work at the Institute, it would provide a ferment for the entire system.

(3) At the present time, some research is done at the various State hospitals by members of their staffs. There is, however, a real need for some leadership, guidance, and coordination of this research. While the work would be done in the separate hospitals, the leadership, guidance, and coordination should come from the Institute and its Director.

In other words, the Institute should be an integral part of the State hospital system providing a dynamic stimulus to teaching, research, and modern methods of therapy in each of the State hospitals. Only to the extent that the Institute raises the standard of the system on the whole is it meeting the purpose for which it was organized. This purpose it is not meeting now and this fact has been recognized over the years past by the Director of the Institute and many of the physicians in the State hospitals. Failure to accomplish this purpose has not been the fault of the Institute nor of the physicians in the hospital system but rather a lack of leadership and imagination in the Department.

Syracuse Psychopathic Hospital

This hospital was established as the State Psychopathic Hospital at Syracuse University by Chapter 346 of the Laws of 1926. It was opened on December 26, 1930. By Chapter 295 of the Laws of 1930, it was provided that this hospital shall be under the "supervision, direction, and control of the Commissioner (of Mental Hygiene), and, subject to legislative appropriations, it shall be maintained as a part of the institutional system of the Department of Mental Hygiene."

In 1935 it was provided by law that—

> "The methods of procedure for the conduct of State hospitals and State psychopathic hospitals, including the admission, discharge, parole, and transfer of patients, provided in this chapter, shall apply to Syracuse Psychopathic Hospital, but the Commissioner is authorized to establish such additional rules and regulations for the conduct of the hospital as he shall deem reasonable and necessary; . . . "

No additional rules or regulations for the conduct of the hospital have been promulgated by any Commissioner.

This hospital has a rated capacity of sixty; it has accommodations for sixty-six patients. For the fiscal year ending March 31, 1943 it had a staff consisting of three physicians, forty-three ward employees (of whom fourteen were graduate nurses), and twenty-one other officers and employees. During this past fiscal year there was a daily average population at the hospital of only 35.62 patients. In the previous fiscal year the average daily population was 52.11 patients.

The average daily population for these two years, as compared with the staff, was as follows:

Fiscal year	Average daily population of patients	Average number of staff
1942	52.11	67 (as at June 30/42)
1943	35.62	78 (as at March 31/43)

The ratio of employees to patients in the other State hospitals for these years was one employee for 4.86 patients in 1942, and one employee for 5.5 patients in 1943.

The average per capita cost of the care of the patients in other State hospitals for the fiscal year ending June 30, 1942 was $401.46. At Syracuse Psychopathic Hospital this average per capita cost was $2,780.11 for the fiscal year ending June 30, 1942 and $2,753.17 for the nine month fiscal period ending March 31, 1943 which, if computed on a twelve month period, would amount to $3,670.89 or at the rate of $10 a day per patient. The total amount spent by the State for this institution in this nine month fiscal period was $98,067.91.

These figures raise an immediate question as to whether the services rendered to the hospital system at this institution warrant these over-all expenditures. There are three needs which it might

be assumed could be met by an institution such as this: (1) It could render a specialized type of service not available generally in the State hospitals; (2) it could be a research institution; or (3) it could be a teaching institution. None of these needs is met, however, by this institution as it has been run since its opening.

The Superintendent frankly admitted that there is no service rendered to patients at this institution which is not available at the State hospitals. The average stay of a patient at the institution is twenty-eight days. If he cannot be discharged within this twenty-eight day period, he is ordinarily transferred by commitment to a State hospital. In the fiscal year ending March 31, 1943, of the 416 patients discharged, the discharge of 170 was merely a commitment to a State hospital. Of the so-called recovered cases during that year 65 per cent were alcoholics. This institution has been operated as a reception hospital similar to psychopathic reception hospitals, which in other large cities are maintained at city or county expense, while this one is maintained at the expense of the State.

The Superintendent also admitted frankly that the institution is not a research institution and that no research is done there that is different from the type done at any other State hospital.

The Superintendent of the Institution is on the staff of the Syracuse University Medical School. He receives $8,500 a year from the State for acting as Superintendent of the Psychopathic Hospital and $2,000 a year additional from the Syracuse University Medical School for teaching. He stated that he spends approximately one-third of his time in connection with his teaching work at the Medical School. He stated that the other two physicians on his regular staff did not teach at the University. The students at the Medical School visit the institution and get clinical experience with the patients. However, it may be pointed out that any teaching institution in psychiatry which has to justify its existence should have some knowledge of the methods and procedure of shock therapy. It is a striking commentary on this institution that at no time during its existence has it ever employed shock therapy. Students at the Medical School, in order to learn about shock therapy, find it necessary to go to Marcy State Hospital rather than to get their instruction at the Syracuse Psychopathic Hospital. At no time has the Superintendent had any of his staff take instruction in shock therapy.

A striking commentary on the operation of this hospital is that in the past year the Superintendent closed two of the six wards justifying this on the ground of "shortage of ward employees." As a result, numerous patients who could have been kept and treated in this hospital have been shipped out to Willard State Hospital, Marcy State Hospital, and Utica State Hospital, where the shortage of employees and inadequacy of accommodations are much more acute than at this institution.

As at present operated there is no excuse for this institution. The State is neither justified in spending almost $150,000 a year merely to provide teaching facilities in psychiatry for the students at

Syracuse University Medical School, and inadequate and outmoded facilities at that, nor is the State justified in spending this amount for a mere reception hospital in Syracuse.

It may be that with an able imaginative Superintendent the institution could be transformed to the full extent of its facilities into a hospital for the specialized treatment of certain types of mental illness and thereby justify its existence both as a hospital and a teaching institution. To accomplish any such transformation in its functions would need a change in point of view in administration of the institution. It cannot justify its existence merely by acting as a reception center.

Nursing Education

Nursing schools have been conducted in some of the Department institutions since 1891. The number of such schools has increased from time to time until today there are eighteen accredited schools in the Department offering a three year course. Thirteen of these schools and two of the institutions which do not conduct the full course have been approved for affiliation with general hospital schools, whereby students from the latter are received for three months' instruction in psychiatric nursing.

The primary purpose in establishing nursing schools in these institutions was probably the preparation of graduates who would be qualified for and interested in continued employment in them; in other words, the schools were expected to be a source of supply of graduate nurse personnel. Other motives may have had a part, as illustrated by the statement of one hospital Superintendent that, "We ought to have a nursing school here because we have an excellent clinical situation for a school and because students are always available to fill in for night duty or other special needs when you can't get a graduate." Others maintain that student nurses are a wholesome stimulation to the medical and graduate nurse staffs in keeping "on their toes" professionally. It is generally agreed that more nurses need to know more about the mental care of every patient in or out of hospitals.

Whatever the purposes may have been, the results have not been entirely a matter for pride. The existing schools as a group do not compare favorably with the other accredited schools in the State. Their faculties are less in number and in preparation than those of other schools; the teaching equipment (laboratories, libraries, etc.) is below average; they have a comparatively poor record in the State licensing examinations;[3] in spite of high student

[3] Results of State Board Examinations 1935–42 inclusive

	Department Mental Hygiene Schools	All other schools
New Candidates	1,404	16,959
Failures	224	2,030
Percent of Failures	16	12

Failures of the Mental Hygiene Department Schools were one-third higher than the average for other schools.

stipends they have not been able to enroll the desired number of students; their better graduates in recent years have sought employment elsewhere.

The Utica State Hospital students receive instruction during the preclinical term in a central school conducted cooperatively by several schools in that locality; hence these students are taught this part of the curriculum by well prepared nurse instructors. In all other Department schools the preclinical teaching is done entirely in the home school. In some schools all of the teaching of regular and affiliating students and attendants is done by the principal and her assistants with such help as is available from staff doctors, pharmacists, laboratory technicians, and dietitians. In the majority of the schools one or more supervisors or charge nurses are "detailed" to teaching full or part time, thus lessening the amount of supervision on the wards. The nurses so "detailed" are for the most part not prepared to teach but are selected for their interest and willingness to cooperate in this phase of the program.

The following table shows the academic preparation of the nurses who gave the preclinical teaching in these schools (except Utica) last year:

	Positions filled	Less than 4 years' High School	H. S. Grad. No college	College No degree	Bachelor's degree	Master's degree
Principals	17	2	4	8	3	0
Assistant principals	15	4	0	9	2	0
Instructors	19	2	4	6	6	1

Dietetics courses were taught in 1942–43 by graduate dietitian instructors in not more than six of the schools, in at least nine by graduates of two year home economics courses not designed to prepare hospital dietitians, and in at least one by a nurse without special preparation in dietetics.

The ward teaching which is an essential part of the clinical curriculum is done by the supervisors and head nurses. The educational background of these groups was analyzed in three schools having a total of one hundred forty-eight nurses in such posts. Fifty-eight were high school graduates, twenty-nine had had some high school work, and sixty-one had no high school record. None had had as much as a year of college work. Nine had had their nursing course in a general hospital school while one hundred and thirty-nine were graduates of schools in psychiatric hospitals, the majority from the same hospital in which they are now employed.

The "bricks without straw" demand upon these schools to educate students without educators goes further in expecting them

to accomplish this end without tools in the shape of adequate teaching laboratories or libraries. In this respect the Utica School is an exception because it benefits by its participation in the central school. Of the remaining thirteen schools visited, four are still without adequate nursing arts' laboratories; seven have no science laboratory (for teaching anatomy, microbiology, and chemistry); three have inadequate and three fairly satisfactory science laboratories. In two there is no dietetic laboratory while in each of the other eleven there is a fairly adequate one. Each school has at least one satisfactory lecture room but the libraries are for the most part rather meagre in content and not well housed; in three schools the books are kept in an office as there is no separate library room.

Prior to the war there had been for some years a tendency away from the paying of student stipends among independent nursing schools. While the value of students' services to the hospitals in which they practiced was still recognized, the costs of teachers' salaries, teaching equipment, etc., made the conduct of a good school increasingly expensive. The majority of schools, therefore, in recent years have either considered the education given as compensation for the service received or have charged a fee to cover the added cost to the school. The Department has continued to consider students as civil service employees and to pay a monthly stipend for the twenty-four months each student spends in the institution. It might have been expected that many candidates would be drawn to these schools because of this economic advantage, but even this failed to attract the number of students desired. In October 1943, the eighteen Department schools had a total enrollment of six hundred and nine students, an average of thirty-four per school, while the average enrollment in the one hundred and three other accredited schools in the State was one hundred and thirteen. Total admissions to nursing schools in the State were higher this fall than ever before, yet the Department schools admitted fewer than for several years past. In fact, the sum of their admissions was one hundred and eighty-one which, had they been evenly distributed, would have been ten students per school.

The increasing difficulty which these schools are having in attracting desirable students has a number of causes. Candidates for admission to nursing schools are being given more guidance generally in the selection of a school. They are learning, more of them each year, to inquire into such pertinent factors as number and qualifications of the teaching faculty, the kinds and amount of clinical experience offered, the teaching equipment, residence conditions, social opportunities, vacations, ward duty hours, etc. The unfavorable comparison they find between these and other schools in respect to teaching faculty and equipment has already been discussed.

Such a person as a social or health director is quite unknown in these schools. Some of the institutions have requested and obtained one or two housekeeper items for the women students' residence, thus making possible the presence of a mature woman in the building for either eight or sixteen hours a day. Some have not provided even this much supervision but expect the overburdened principal and assistant principal to function also as residence, social, and health directors. For example, in one place where there is just one housekeeper from 7:30 A.M. to 4:00 P.M. six days a week, the principal and assistant are required by the administration to remain in the residence continuously over alternating weekends although they both reside outside of the institution. Furthermore, these two with some assistance from supervisors and head nurses have to alternate for week-day evenings and to cover for the housekeeper during the latter's absence for vacation, illness, or other cause. Students also are often required to answer door bells and telephone during the evening hours.

Colleges, well conducted nursing schools, and other organizations where young students are in residence have long considered supervisory personnel essential to maintenance of health and morale and to the cultivation of desirable living habits among students. Men students as well as women need and deserve such supervision.

An insufficient regard for the health of students is manifested in their civil service classifications which restrict vacations to two weeks and illness allowance to twelve days a year. This is an important reason why students should be removed from civil service. This listing which should protect them from excessive duty hours is, in at least one situation, having just the opposite effect. Here officers of the institution make frequent demands for so called emergency night nursing by students who have been on day duty the preceding day, that is, they are commonly requiring a student to work two eight hour periods in the same day. In this connection attention is called to the fact that practically all student nurses are in their late teens or early twenties, the age group most susceptible to tuberculosis.

Because the great number and variety of psychiatric cases treated in the State mental hospitals make them the best clinical field available for psychiatric nursing experience, schools in general hospitals which have no psychiatric division send their students to the State mental hospitals for a three month period of instruction and experience in this field. The number sent has increased every year as more and more schools have come to regard such training as essential for every nurse and as the general hospital schools have increased their own enrollment. Last year 1,502 affiliating students spent three months in the fifteen Department hospitals approved for this course. In the light of these facts, the very small number of nurses who have had this affiliation and who are interested in returning to these institutions for employment after graduation is striking. A study of three institutions with a total of 206 employed

graduate nurses showed that only fourteen were from general hospitals while 192 were from schools located in mental hospitals. Even before the war every one of the Department hospitals had places for graduate nurses either vacant or filled by attendants because registered nurses were not available.

It seems fair to predict that competition in securing both students and graduates will be no less keen following the war than now as candidates become increasingly informed and more opportunities for graduates are opened.

An attempt to bring the eighteen existing Department schools up to a good standard would be wasteful and ineffective because the number of qualified teachers and the amount of equipment needed for eighteen schools would be expensive and, at least during the war and the immediate postwar period, quite unprocurable. Centralization of pre-clinical education for economy and efficiency seems both desirable and practicable.

It is the opinion of this Commission that a single centralized school should be set up under control of the Nursing Division of the Commissioner's office. The existing schools would then become clinical teaching units of the central school to which students would be assigned for their practical ward work after completing their preliminary pre-clinical courses. For the pre-clinical teaching it would probably be advisable to establish two or more regional teaching centers. These centers presumably would be located at State mental institutions where adequate facilities for teaching are available and where suitable teachers could be secured and retained.

The State Department of Education now requires a period of one year affiliation in general hospitals for students in the schools of the State mental institutions. This affiliation would be continued as heretofore.

The central school with its branch teaching centers should be under the direction of a qualified nurse educator appointed by the Commissioner on recommendation of the Department Director of Nursing and responsible to that Director for the selection and admission of students, the plan and conduct of the curriculum, the placement of students in the hospital divisions for nursing practice, and all other matters pertaining to the school program.

Students should not be thought of as working for the hospital and available to fill gaps in the employee ranks, but should be given the same status as that of students in other educational institutions. State scholarships for needy students should be made available to those who merit such assistance. Men and women should be admitted on an equal basis.

By such concentration of resources it should be possible to secure a strong faculty, and the best of teaching equipment, provide good living conditions in a desirable location, and compete successfully with the best schools in the State in attracting desirable students.

Students from schools outside of this system should be received by affiliation for training in psychiatric nursing through the

central schools rather than directly by each hospital as heretofore. The best facilities of the school should be utilized to improve the program offered to affiliating students in order to retain the existing affiliations and encourage new ones. Development of this phase of the educational program is important, not only in order to interest more graduate nurses in employment in the mental hospitals, but because all community nurses need to be better prepared to assist in the prevention of mental illness.

It is further recommended that with the elimination of the title of attendant and the adoption of the regrouping suggested in the Chapter on The Personnel of The Department, there should be established within the Department a central school for the training of practical nurses. This school, which should at least meet the minimum requirements of the Board of Regents for an approved practical nurse school, should be directed by a principal responsible to the Department Director of Nursing for the program in its entirety as previously indicated for the central school to prepare professional nurses. The cost of conducting the school and of maintenance for those enrolled in it should be borne by the State.

It is possible that many persons now or previously employed as attendants in these institutions may meet requirements for admission to the practical nurse school, and if so, they should be encouraged to apply in order to become classified under civil service as practical nurses. Members of this group should be admitted on exactly the same basis as all others enrolled in the school.

In addition to establishment of central schools on the two levels dealt with above, it is hoped that, following the appointment of a Department Director of Nursing to assist in guiding and coordinating the whole nursing education system, there may be set up a course in psychiatric nursing for graduate nurses who desire to make this field a specialty and who seek to prepare for teaching and supervisory positions in mental institutions. The sponsorship of a recognized university or college able to offer courses in nursing administration and nursing education should be sought for this program which should be organized in harmony with the policies of the Association of Collegiate Schools of Nursing.

By a plan of centralization as outlined in the foregoing paragraphs, the individual institutions of the Department would be relieved of the responsibility for conducting professional or practical nursing schools or courses. They would, however, continue to benefit by the presence of student nurses from the Department's central schools and affiliating organizations, assigned through the central school to the institutions for nursing practice. Such a plan would make possible a much stronger nursing education program than could ever be developed in a number of separately conducted schools.

CHAPTER IV

PHYSICAL PLANTS

The twenty-six institutions in this Department represent an investment by the State of New York of $188,000,000. They cover 21,872 acres of ground and range from buildings erected a century ago to buildings only recently completed and not yet equipped.

The New York State Lunatic Asylum at Utica was authorized in 1836 and in 1843 received two hundred and seventy-six patients. This institution is now Utica State Hospital and the main building in use today is that which was erected one hundred years ago.

The older institutions grew up without an over-all guiding plan and in many cases utilized structures which had been designed and built for other purposes. The main building at Binghamton State Hospital was built originally in 1860 as an asylum for inebriates. The principal building at Newark State School was occupied in 1878 having been designed for use as a private school. When Manhattan State Hospital was opened in 1871, it took over some buildings on Ward's Island which for a number of years had been in use as an immigration hospital. Even as late as 1924 Harlem Valley State Hospital took over buildings which had been erected as cell blocks for a State prison.

Under such circumstances it is not surprising that the earlier buildings were not appropriately designed for use as State hospitals or State schools. Although, of course, many of the old buildings have been reconstructed in part, they nevertheless present problems which do not exist in more modern buildings. Many of them, for example, have wooden floors which are an ever present fire hazard. In many of them a constant battle has to be waged against rodents and vermin. Some of the old buildings at Willard State Hospital and at Binghamton State Hospital need complete reconstruction before they can be considered either safe or adequate for the care of mental patients. Under Chapter 717 of the Laws of 1941, Manhattan State Hospital is to be closed in 1948 and the property turned over to the City of New York for use as a park. If this institution were to be continued, it would need substantial reconstruction.

In some of the old institutions no proper provision was made to house the medical staff with the result that doctors and their families have had to live in rooms and apartments in the same buildings with patients. For a physician to be forced to bring up his children in an apartment in the same building with throngs of mentally diseased patients is a deterrent to securing an adequate medical staff.

The buildings erected since the turn of the century have in most cases provided more adequate accommodations both for employees

and patients. Since 1923 the Department has had a standing committee on construction. This committee has concerned itself chiefly with the planning of interior and service arrangements of new buildings, leaving the general planning to the State Architect. There are, however, certain aspects of the physical plants of the Department which need immediate attention.

(1) Construction and Planning

There are good arguments from an economic point of view to support the value of such enormous institutions as those caring for 5,000 patients and more. There is little doubt, however, that size has an important bearing on the quality of medical care. Patients in large hospitals cannot receive the same amount of individual attention as those in small hospitals. The care given to patients becomes mechanical and flows along the lines of mass production. The details of administration even with good assistants become more difficult to follow. Policies are made to fit the size of the plant rather than the patients' needs. In extending a plant the tendency is to add buildings for patients without a corresponding increase in service facilities.

Buildings for the care of the mentally ill should, to serve their purpose, be appropriately designed so as to put the emphasis on the care and rehabilitation of the patients rather than merely on their custodial care. Too often in the past buildings have been erected of the skyscraper type which are adequate for bed patients but make it almost impossible for ambulatory patients to get out into the open and secure fresh air and exercise which are prime requisites for better mental health. The continued treatment buildings at Brooklyn State Hospital are typical of this type of structure. The three storied buildings for the accommodation of patients, such as are found in the prison-like Orleans group at Rochester, erected in 1938, have added great difficulties to giving the patients open air recreation. On the other hand, the Howard group at Rochester, built five years earlier, is not only limited to two stories in height but also provides enclosures where patients may come and go at will under minimum supervision. The design of Edgewood State Hospital, which has recently been completed, but not yet equipped, points in the proper direction. This institution has a tall building designed to house the bed patients and to contain the medical and surgical facilities. The buildings for other types of patients are low structures allowing easy access to the grounds.

In those institutions having tall buildings, few if any patients were seen in the open air, whereas at Central Islip a large proportion of the patients go out of doors on each bright day. The patients who are able to be out in the open and receive some exercise show the benefit in being less disturbed at night.

Very few of the institutions have any enclosed space adjoining

the buildings to which the patients may go for exercise. Failure to provide these exercise yards, even in modern institutions such as Creedmoor State Hospital and Pilgrim State Hospital, leads to the regimented marching of patients through the hospital grounds. This is of little help in the attempt to return patients to a normal way of life. It is poor therapy to keep patients herded in a crowded room when with little planning they could be given an opportunity to be out of doors. Rockland State Hospital has solved the problem in part by fencing off a space between buildings and covering this fence with green burlap. This provides an excellent area for the patients from the adjacent buildings. In all future planning it would seem desirable to provide for exercise yards directly connected with the buildings so that the patients would receive their exercise in the open air with a minimum of additional supervision.

In planning even the latest hospitals insufficient attention has been given to the maintenance of a proper balance between bed and ambulatory patients. At Pilgrim State Hospital an infirmary was built in the last decade to hold 1,018 patients. Today it has been necessary to place in this building 1,708 beds, an average overcrowding of 67 per cent, while the total overcrowding in the institution is only 10.3 per cent.

The failure to provide covered passageways between the residence buildings and the dining halls presents serious health problems, particularly in the State schools. Wassaic State School, which was opened in 1930, has been built with an orderly arrangement of buildings but no protective passageways were provided between the dormitories and the dining halls. As a result, the thousands of mentally defective children who are patients of the school have to tramp three times a day through the rain and snow for considerable distances from their residence buildings in order to get their meals. They frequently arrive at the dining halls wet through and must eat in damp clothes and with wet feet and return in the same condition to their residence buildings before they can change their shoes or clothes. This unnecessary exposure to the elements indicates a lack of consideration for the health of the patients in designing the buildings. Willowbrook State School, a still later example of planning, also was not provided with covered passageways to the dining halls. It is noteworthy, however, that as soon as the army took it over for use as Halloran General Hospital it erected covered passageways.

The above are merely some of the indications of the lack of consistent and functional planning in the Department. While decided progress has been made in this respect in the last twenty years, there is still great need for improvement.

(2) Provision for the Tuberculous Patients

In the chapter on Professional Care of Patients, reference has been made to the large number of tuberculosis cases found in the State mental institutions. Until recently very little has been done

toward effective segregation of these patients. Even today we find overcrowded wards for the tuberculous patients in the acute hospital building at Letchworth Village where all patients are fed from the same kitchen. At Kings Park State Hospital, five hundred fifty tuberculous patients occupy part of a group housing 1,800. In a number of other institutions little if any effective segregation is employed.

A combination of mental illness and tuberculosis presents unique problems. The patients in many cases cannot be trained to observe ordinary sanitary precautions which are necessary to prevent a spread of the disease. Nurses and attendants taking care of such patients must be specially trained in precautionary measures. From this standpoint it is uniformly recognized that the only effective segregation of tuberculous patients with active disease can be accomplished by their hospitalization in buildings specially designed and set apart for the care of such patients, or in separate institutions. Each tuberculosis hospital would have to have a staff of physicians specially trained in tuberculosis with adequate laboratory and x-ray facilities.

At Central Islip State Hospital there is a unit especially designed for the care of tuberculosis. This was completed in 1940. It is built on a plan of single storied pavilions, each with a peaked roof, connected by a long corridor. Although completed within the last three years, this unit for tuberculosis does not conform in plan with modern tuberculosis hospitals which largely follow the design of general hospitals for acute diseases. This unit is designed to house over 1,000 patients. There are, however, in the Department approximately 5,000 patients requiring special care as a result of tuberculosis.

For the better treatment of these patients and for the safety of the other patients and employees, it is recommended that special hospital buildings be included as one of the first items of a post-war planning program to house all the tuberculous mentally ill so that they may effectively be segregated and treated. It would be desirable that such hospitals be located near the State hospitals for the tuberculous now maintained by the Department of Health so that the Department of Mental Hygiene would have the advantage in treating these patients of close contact with the medical staffs of the hospitals which are specializing in the care of tuberculosis.

(3) Maintenance

It would seem that more attention has been given to the construction of new units than has been given to the maintenance of the buildings in the Department. Through a failure to insist upon a regular and definite program of maintenance the Department is now faced with the problem of building upkeep when much of the needed repairs could have been accomplished years ago. There are, for example, such items as unpainted outside wood work in recently constructed buildings at Willard State Hospital. At Har-

lem Valley State Hospital subsurface passageways are inundated after each rainfall. At Rockland State Hospital there are reciprocating engines unused because of faulty governors. At Binghamton State Hospital and Syracuse State School, baseboards have drawn away from the floor and painting has been neglected for many years. At Harlem Valley State Hospital a ceiling has fallen due to a leaking roof. At Wassaic State School there have been many roof leaks. At Pilgrim State Hospital not only have roofs had to be repaired but sidewalls waterproofed as well, and as a consequence wards have recently been closed in order to renew the plaster.

A current program of adequate maintenance would be an economy in itself. The institutions have in many cases observed a policy which was penny wise and pound foolish and have allowed buildings to deteriorate which could have been kept in good condition by a prompt expenditure of relatively small amounts of money.

Although the State appropriated in the ten years from 1933 through 1942 the sum of $1,371,090 for maintenance materials in six hospitals, there was left unexpended by these institutions from this sum the amount of $155,646. Here was a case where funds were made available by the State but were not used either because of faulty planning or faulty supervision. At Gowanda State Hospital, for example, where some of the patients' rooms had not been painted for fifteen years and where outside metal work in the newer buildings was badly rusted from lack of attention, there were $39,136 of funds appropriated for maintenance materials over this period which had not been used. This was not because of war conditions, for the unexpended balances existed for many years before the war.

The remedy for these conditions can be found in (1) the employment on the central office staff of an active supervising engineer and (2) the establishment of a yearly reserve for repairs and maintenance to be placed at the disposal of the Department for allocation where it is most needed.

(4) Fire Prevention

A report on certain hospitals in this Department was prepared by the National Board of Fire Underwriters in 1923 giving in detail the fire hazards which existed and their recommendations regarding what should be done to correct these hazards. At that time the amount of $750,000 was appropriated to carry out in part the recommendations made by that Board. These funds were spent principally to regularize the proper number and type of exits and for the installation of sprinklers.

The Commission believes that a new survey should now be made by the National Board of Fire Underwriters taking in all buildings of the Department so that expert advice may be secured as to possible fire hazards and recommendations with reference thereto. In the last ten years there have been twelve fires in institutions in this Department where the loss was over $1,000 in value with an aggregate damage from them of about $175,000.

(5) Service Equipment

The disadvantage of incomplete planning show clearly in the unbalance of the service units. We find water shortage at Rockland and Letchworth, excessively cramped quarters for the inadequate bakery at Newark, eight boiler plants in need of rebuilding or additions, and storage facilities in eight institutions which have not kept pace with the increase in patients.

The absence of constructive, long range planning, therefore, seems to be the basic reason for present conditions. The Commission recommends that the Committee on Construction of the Quarterly Conference, now composed of Superintendents and a representative of the Department of Public Works, be properly aided by calling on experts in the various fields of hospital construction and its duties enlarged to cover the whole construction field of the Department.

(6) Farms

On 12,000 acres of land both State owned and rented, the institutions of the Department are raising farm products valued at wholesale prices at over $1,000,000. Twenty-three of the institutions have farms ranging from an investment value of $1,200 to $200,000.

The Agriculture and Markets Law states that "The Commissioner shall give such direction as in his judgment is deemed best to each Superintendent, warden, or other person in charge of the several farms connected with the State institutions above mentioned as to proper care and development of farm lands and as to kind, production, and disposition of crops, stock, and produce and all other matters connected with the management of such farms." The Commissioner of Agriculture through the Division of State Institutions Farms has wisely interpreted the law in such a manner that the Division of State Institutions Farms is more of an advisory than a control agency. However, it is felt that closer coordination of the Department of Mental Hygiene with the Division of State Institutions Farms is essential, if the farms are to be run at greatest efficiency. In order to secure this coordination it is recommended that the Department employ a Director of Farms. The Department has an enviable opportunity to set an example to the farming industry of the State but it must not be forgotten that the farms exist primarily to help in the task of training and rehabilitation and to produce food for patients and not to show a profit.

Seventeen of the institutions maintain dairy herds but in five their own production is supplemented from commercial sources. Fourteen maintain their own pasteurizing plants. The Division of Sanitation of the Department of Health indicates that in thirteen herds the quality of the raw milk is poor and in only three is it classed as good. In one it is classed as fair. In eight of the herds the cows with mastitis are not segregated and in three others the Division of Sanitation recommends the elimination of cows with

mastitis. The presence of mastitis may well account for the poor quality of the raw milk.

All institutions are now using pasteurized milk but the Division of Sanitation reports that the pasteurizing equipment of seven is fair and that of three is poor.

Below is a table of statistics representing the results of the latest inspections of the Division of Sanitation.

	Pasteurized	Own plant	Commercial plant	Own herd	Commercial	Own Supply			No recent inspection	Mastitis
						Good	Fair	Poor		
Kind of milk used	26	...	...	...	...	...	...	...	...	....
Where pasteurized ‡	...	14	14	...	...	...	...	...	...	....
Sources of raw milk	...	...	...	17	14	...	...	...	...	....
Quality of raw milk *	...	...	...	...	...	3	1	13	...	....
Dairy farm equipment †	...	...	...	...	...	5	4	3	5	....
Dairy farm operations	...	...	...	...	...	6	2	4	5	....
Quality of pasteurized milk	...	...	...	...	...	12	4	0	1	....
Pasteurizing plant equipment	...	...	...	...	...	7	7	3	...	....
Pasteurizing plant operations	...	...	...	...	...	12	4	1	...	....
Cows with mastitis not segregated	...	...	...	...	...	...	...	...	...	8

* Quality of raw milk is rated according to results of laboratory examinations of milk samples. A conclusive opinion cannot be made without the results of frequent physical examinations of the herd. Rating of "poor" is given when examination of milk shows more than 500,000 cells per ml. which is an indication of mastitis.

† Emphasis in supervision has been placed upon pasteurizing equipment and its operation, as this phase of milk handling is the most important factor in producing safe milk.

‡ "Commercial" indicates supply from an approved commercial pasteurizing plant which is under constant supervision of local and State health departments.

The Commission recommends with reference to the farms that:

1. All pasteurizing plants be equipped as soon as possible in accordance with the recommendation of the Division of Sanitation of the Department of Health.

2. The Department insist on the segregation of cows having mastitis.

3. All cans of pasteurized milk be sealed with wire and lead seals at the pasteurizing plant and that, when available, milk dispensers of a type approved by the Division of Sanitation be used at all points where milk is dispensed.

4. Phosphotase tests be made routinely on samples of pasteurized milk and cream as recommended to the Department by the Division of Sanitation in its letter to the Commission of November 28, 1943.

5. As soon as practicable the employment of patients be discontinued in the milking of cows, in the washing and sterlizing of containers and equipment, and in the handling of pasteurized milk except in sealed cans.

6. Milk be pasteurized in commercial plants unless a competent operator is placed in charge at each pasteurizing plant.

7. Intensive efforts be made to increase the productivity of the milking herds.

CHAPTER V

REIMBURSEMENT FOR PATIENT CARE

The institutions in this Department are maintained "for the care and treatment of poor and indigent persons" (Mental Hygiene Law, Sec. 24-a). A "poor person" is defined in the law as "a person who is unable to maintain himself and having no one legally liable and able to maintain him," and "an indigent person" is a person who has not sufficient property to support himself and "to support the members of his family lawfully dependent upon him for support"[1] (Mental Hygiene Law, Sec. 2). However, the law has always contemplated that the legally liable relatives of an indigent person shall be liable for the cost of the care and treatment of the patient in a mental hospital or State school. The persons legally liable under the law are the husband, wife, father, mother, and children of the patient (Mental Hygiene Law, Sec. 24-a, Subdivision 2). These are some of the persons who are responsible under the law for the support of such a relative, even if he or she were not confined in a mental institution (Social Welfare Law, Sec. 101).

It is fair and proper that these designated relatives should provide for the support and maintenance of a person in a State hospital or State school if financially able to do so, for otherwise they would, by committing a relative to such an institution, escape an obligation which would be imposed upon them if the relative were maintained at home. The provisions for the collection of funds for patient care are now embodied in Section 24-a of the Mental Hygiene Law. This statute provides that these relatives are liable for the cost of care and treatment of the patient. This cost is determined by taking "the total direct and indirect cost to the State for the care and treatment of patients for the preceding fiscal year, which total cost shall be divided by the average daily patient population for that year of patients in all State institutions under the jurisdiction of the Department of Mental Hygiene, and the per capita cost arrived at shall be the cost of care and treatment of such patient." However, the liability of the relatives of a patient for payment of such cost has the limitation that they shall be so liable only "if of sufficient ability" (Sec. 24-a, Subdivision 2).

The Commission has made an investigation to determine whether the provisions of the statute are being complied with, and relatives "of sufficient ability" are paying for the cost of the care and treatment of patients for whom they are legally liable, or whether this statute is being applied in an inefficient and discriminatory manner, so that some persons are paying for the care of their

[1] The Commissioner may, however, permit persons who are neither poor nor indigent to be received and maintained in an institution conditioned upon prompt and regular payment for their care and treatment. (Mental Hygiene Law, Sec. 24-a.)

relatives while others are not. The investigation discloses that for the fiscal years 1941 and 1942 only the following per cent of patients were having reimbursement made for them, and such reimbursement was made for such patients in the following amounts:

Year ending 6/30	Number	Per cent of total patients in the institutions	Amount collected per paying patient	Total collected
1941	8,059	11.0	$311.60	$2,511,160.83
1942	8,464	11.4	328.77	2,782,687.45

It is the estimate of the attorney in charge of the Reimbursement Bureau of the Department that, if properly applied, the provisions of the statute would result in reimbursement for approximately 25 per cent of the patients in the hospitals. If this is true, there has been approximately $3,000,000 annually which properly should have been collected by the State from relatives legally liable and with sufficient ability to pay but who have avoided paying.

(1) Determination of the Extent of a Relative's Ability to Pay

The collection of funds for patient care is the duty of the Reimbursement Bureau of the Department. This Bureau has Special Agents attached to each of the following hospitals: Buffalo, Rochester, Willard, Syracuse Psychopathic, St. Lawrence, Utica, Middletown, Binghamton, and Hudson River. In addition, there is an agent who operates out of the State Office Building in Buffalo, and agents who have operated out of the State Office Building in New York City.[2] These agents each have certain institutions assigned to them. When a patient is admitted to the hospital, the names and addresses of the patient's relatives and such other information as is obtainable regarding the financial ability of the patient or those legally liable for the patient's care, is required to be secured and forwarded to the Special Agent. In actual practice the only information usually obtained is the name or names and addresses of the relatives. Upon receipt of the admitting information, the agent forwards to the person or persons legally liable a questionnaire for such person or persons to furnish information as to financial ability, as well as any information which they may have regarding any property belonging to the patient. This questionnaire is not required to be notarized and there is no provision in the law providing for any penalty for a wilfully false return.[3]

No verification is made by the agent to check the correctness or the truth of the information set forth in the answers to the question-

[2] Commissioner MacCurdy has recently decentralized this office so that the agents in this area will also be attached to particular hospitals.

[3] This questionnaire has on it a preliminary statement to the effect that it is not the policy of the Department of Mental Hygiene to collect reimbursement when such payment seriously interferes with the standard of living of the persons legally liable, or prevents them from meeting their usual obligations. This statement is much broader than the law and constitutes an invitation to color, if not deliberately to falsify the information given.

naire as to the financial ability of the persons legally liable. After the agent has examined the questionnaire, and relying upon the answers, he fixes what is known as a "recommended rate" to be paid by the person or persons legally liable. The original of the questionnaire with the "recommended rate" is then sent to the Albany office of the Department for approval or disapproval.

In fixing the "recommended rate," the agent follows no prescribed formula nor does he have any established standard of "ability to pay" to guide him in his determination as to the rate to be charged to the persons legally liable. In the Albany office there likewise is no formula or standard. As a result the rates fixed have shown wide variations resulting in gross inequalities. A spot check has been made of several hundred recent cases which shows no consistency in the determination by the agent as to the amount which should be paid for the support of a relative. In one case, for example, the combined income of two persons legally liable, with no other dependents, aggregated over $225 per month and the rate fixed for the support of the relative in the hospital was $5 per month. In another case, the person legally liable had an income of $160 per month and was compelled to support from it a dependent son. Nevertheless, he was directed to pay $25 per month for the support of his relative in the State hospital. Similar disparities can be multiplied many times by reference to the files of the Reimbursement Bureau.

It need hardly be pointed out that where the Special Agent and the Reimbursement Bureau have power to fix rates with no established standard by which their determination can be judged, a wide gate is open for favoritism and discrimination. The Chief Agent of the Reimbursement Bureau in New York frankly admitted upon examination, that in past years politicians had sought special privileges for persons for whom they were interested in securing a reduction in rates.

It is a startling fact that until 1942, after a rate had once been fixed, no subsequent questionnaire was sent to the relative unless the persons legally liable requested a reduction. Thus, a rate once fixed was, as a practical matter, frozen forever even though the persons legally liable became affluent thereafter. As a result of recommendations of the Health Preparedness Commission of the State, all rates are now supposed to be subject to reinvestigation once a year, except in the case of those patients who have no assets and no persons legally liable for their support. The reinvestigation consists solely in sending out an annual questionnaire; there is no further investigation of the truth or accuracy of the statements made in this subsequent questionnaire.

This reinvestigation as of July 1, 1942 is now proceeding, but has not as yet been completed. Of the 35,380 cases assigned to upstate agents, all questionnaires had been sent out and had been returned as of September 30, 1943. The New York City office had 40,240 cases to reinvestigate, and as of September 30, 1943 had reinvestigated only 7,282 cases. The explanation given for the failure of the New York City office to complete its reinvestigations is

that the work involved in investigating new admissions in this area, plus insufficient stenographic personnel, has made it impossible to keep up to date on new admissions and at the same time reinvestigate the old cases. It would appear, however, that the same vigor in making the reinvestigation has not been displayed by the New York City office as was displayed by the upstate agents, and that the management as well as the personnel of the office was woefully inadequate.

Nevertheless, for the year commencing July 1, 1942 and ending June 30, 1943, there was an increase in the percentage of paying patients from 11.4 per cent to 15.3 per cent, and the total collections for the same period were $760,942.98 in excess of all collections for the period in the previous year when no annual questionnaires were sent out. Some of this increase may be due to improved economic conditions, but there would seem to be little doubt that an annual questionnaire as to the financial ability of the relatives to pay for the care of patients related to them is well worthwhile, and that the Department has for many years past been failing to collect moneys properly due to the State because of its failure to require current information from relatives as to their ability to pay.

In the absence of some check-up upon the truthfulness of statements set forth in answers to the questionnaires, it is impossible to know how much additional money might be collected by the State if the true facts were known as to the ability of relatives to pay. It is a shortsighted policy to accept at face value the answers to questionnaires sent in by relatives. Those who are truthful are penalized, while those who falsify their answers are favored. To accept the answers to questionnaires at their face value is like failing to audit income tax returns. It would, of course, be impossible to check the accuracy of all questionnaires, but it would seem to be a justifiable investment for the State to have a corps of investigators to make a spot check on certain of the answers to the questionnaires. The result would pay substantial dividends, not alone because of inaccuracies that might be discovered in the cases that were investigated, but also because relatives would know generally that their answers to the questionnaires were subject to investigation and check, and would, therefore, be more careful and accurate in their statements.

(2) Collection of Amounts due from Relatives of Patients

When the rate has been fixed by the Reimbursement Bureau, the Steward of the particular institution is notified and he sends out monthly bills for the amounts due. The agent of the Reimbursement Bureau does nothing further in connection with the collections unless an account becomes delinquent. At that time the account is referred to the agent for collection, but there is no prescribed procedure for him to follow in making collection.

There are a number of persons legally liable for the support of their relatives who refuse to pay the amounts due even though the rate has been fixed upon the basis of questionnaires submitted by

them. To allow these persons to escape their obligations, while compelling honest and conscientious persons to pay, is unfair to the latter and to the State. That this condition has been allowed to exist is because of the inertia and neglect in bringing legal proceedings by the State for the collection of funds, and also due to the cumbersome legal formalities needed at the present time.

When the Special Agent has exhausted what seems to him to be reasonable efforts to effect collection, the account is referred to the office of the Department in Albany where the file is reviewed. If the Albany office determines that the account is suitable for litigation, the claim is placed in litigation. In the Albany area, all litigation since January 1, 1943, is handled by the Department's attorneys located in Albany. In all other areas litigated cases are referred to the Attorney General. The records of the Reimbursement Bureau in Albany have been completely inadequate. This Commission has been unable to find any record of the number of delinquent accounts referred to the Attorney General, the number of cases placed in litigation, or the results of the litigation. Commissioner MacCurdy is endeavoring to correct the situation and it is assumed that a system for keeping proper statistical records by the Reimbursement Bureau will be instituted shortly.

As of June 30, 1942, the uncollected balances due to the State from relatives of patients amounted to $6,167,873.21. An analysis of the delinquencies since that date shows a steady decline. As of August 30, 1943, the uncollected balances amounted to $5,557,184.70. That such an amount should be outstanding and uncollected is in itself a startling commentary on the inefficiency of the present system, and the inertia of former Attorneys General in protecting the interests of the State.

Where claims have been placed in litigation, many technical defenses have been advanced, with the result that the Department gradually seems to have fallen into a practice of accepting the best possible compromise that could be worked out. This operated to the advantage of those who failed to pay their obligations and imposed an unfair burden upon those who paid. For example, while the statute states that the rate fixed by the Commissioner shall be presumptive evidence of the cost of care and treatment, experience has shown that in practically all litigated cases the burden for sustaining its rate ultimately fell upon the Department. This involves accounting testimony and computations expensive to present and subject to constant attack. So also, in certain cases, the relatives have claimed that they were not liable to pay the rate fixed because the patient was engaged in vocational work at the hospital, and this despite the fact that the vocational work is very largely a matter of therapy. Also, in the litigation of cases, the Reimbursement Bureau is faced with the problem of presenting proof in each case that the persons legally liable to pay the rate have the ability to do so. The definition of ability varies with the judge or court before whom the question arises.

At the present time the Department, in order to collect moneys due, may bring an action for a money judgment. The Depart-

ment is also empowered under Title 8-A of the Criminal Code to institute proceedings in the Municipal Term of the Magistrate's Court of the City of New York, as well as in the County Court in each county outside of New York City. While the Department has found the County Courts satisfactory, there has been difficulty in utilizing the Magistrate's Court in New York City, because of the feeling of the Magistrates in New York City that failure to pay amounts due to the State should not be treated as a criminal matter. The adequate enforcement of the State's rights in the New York City area is of considerable importance to the Department, since approximately 60 per cent of the patients in the State institutions are admitted from that area.

(3) Collection of Amounts due for the Care of Veterans

The Department has been negligent in failing to secure payment by the United States Veterans' Administration for the care of veterans in the State hospitals. On June 1, 1943, there was unpaid, on account of care and treatment of veterans, the sum of $5,534,510 for 1,324 patients, representing in the aggregate 7,571 years of residence of these veterans in the hospitals. Under the World War Veterans' Relief Act, the Veterans' Administration is authorized to pay the State or Municipal hospitals for the care of veterans suffering from neuro-psychiatric conditions which are "service-connected." The Veterans' Administration has entered into separate contracts with the various hospitals in the Department of Mental Hygiene. These contracts contain a clause to the effect that no payment will be made by the Veterans' Administration unless authorization for the care and treatment is given by the Veterans' Administration. The Department of Mental Hygiene has failed to adopt any systematic procedure for obtaining such authorizations. The representative of the Department in charge of reimbursement matters states, "This phase of reimbursement was strictly neglected because there was no administrative policy to follow, neither was there encouragement given when one was willing to do the spade work in this field." Because of this lack of administrative policy and vigorous action, it is probable that a substantial proportion of the sum of over $5,000,000 has now been lost to the State, which otherwise might have been received by it from the United States Veterans' Administration.

(4) Recommendations

It would seem apparent that in order to avoid discrimination in the collection of funds, and in order that the obligation of persons legally liable to pay should be enforced with uniformity, some consistent procedure should be adopted which would enable the Department to fix a fair rate consistent with ability to pay, which would enable a prompt determination of the ability of the persons to pay the rate so fixed, and allow for prompt judicial enforcement of the collection order when such liability has been so determined. To this end the following recommendations are made by the Commission:

1. At the present time there are thirteen different sections contained in five different articles of the Mental Hygiene Law covering the matter of reimbursement. It is recommended that all sections pertaining to this subject be codified under one article.

2. Section 24-a should be amended by eliminating the provisions which specifically direct the fixing of the rate for care of patients based on direct and indirect costs, and by providing that the Commissioner of Mental Hygiene may fix a standard rate as the basic rate for the care of patients in the institutions. Subject to the determination of the legally liable persons' "ability to pay" as determined in accordance with Recommendation 3, this basic rate, or so much thereof as such persons were found able to pay, would be the amount charged to them for the care of the relative or dependent in the State institution. In addition, of course, the Commissioner's present authority governing "special agreements" for the care of persons who are not poor or indigent should be continued, with power in the Commissioner to refuse to take into an institution a person who is not poor or indigent, unless such special agreement providing for payment at a rate to be determined by the Commissioner shall be entered into by the legally liable persons, and with power in the Commissioner to remove the patient from the institution and to compel those responsible to take care of such patient, where the agreed-upon rate has not been paid.

3. The Department of Mental Hygiene should establish a formula by which is to be determined how much of the basic rate is to be charged to persons for the care of a relative or dependent. This formula in determining the "ability to pay" should take into account the income of the relatives liable to pay for reimbursement, should allow deductions therefrom in fixed amounts for the support of other dependents, and should determine what proportion of the balance, not in excess of the basic rate, should be devoted to the payment for the care of their relative in a State institution. This formula would then be applied by the Special Agents in fixing the rate.

4. The law should provide that within thirty days after the rate has been fixed the relatives should be notified of such determination by registered mail, and that within thirty days from the date of the mailing of such notice, they would have a right to appeal to the Commissioner for a review of the rate fixed. This would enable an appeal to be taken in special cases where unusual circumstances would, in the judgment of the relatives, make the application of the formula inappropriate. The law should provide that the determination of the Commissioner should be in writing and mailed to the relatives legally liable and that these relatives would have the right, within thirty days after mailing of such notice, to appeal from such determination to the Appellate Division of the Third Department. The law should provide that a rate determined as above provided, subject to such right of appeal, should be a final and conclusive determination of the relatives' ability to pay the rate so fixed. This would mean that if the relatives failed to pay this amount, there would be no question which would need

to be litigated except relationship to the patient. This would greatly expedite the securing of the necessary orders for the enforcement of the rate so fixed. The law should, of course, provide that persons legally liable may at any time make application for a revision of rate due to change of circumstances, and that the procedure for determining any revision of the rate, and for appeal therefrom, shall be the same as that provided for the original determination of a rate.

5. All monthly billings for the care of patients should be done from a central office and all collections remitted to a central office. This would provide automatically for a central control of the amounts collected, for prompt ascertainment of delinquencies and for immediate follow-up on these delinquent accounts. For the determination of the relatives' ability to pay it would seem preferable that the agents be stationed at the hospitals rather than in central offices. The annual reinvestigation by sending out supplemental questionnaires should, of course, be continued.

6. The Department of Mental Hygiene should institute a comprehensive system of keeping statistical records of the results of the operations of the Reimbursement Bureau.

7. As to cases in the New York City area, it is recommended that the Department utilize the facilities of the Family Court by securing orders to enforce payment for future care. Inasmuch as, under the system proposed, no question of the ability of the relatives to pay will be presented to the court, the enforcement of the payments of the fixed rate will not impose any further burden on the Probation Department of the Family Court. This court will, however, treat the matter as it properly should be treated, as a matter of the collection of funds for the care of a relative, rather than considering it, as the Magistrate's Court does, in the nature of a criminal matter.

8. The Reimbursement Bureau should be provided with a corps of investigators to check up on the information given by relatives as to their financial resources and income; and the law should provide a penalty for wilfully false or inadequate information in answering the questionnaire concerning their resources and income.

9. An immediate review of all veterans' cases should be instituted to determine which of them are "service-connected", and vigorous steps should be taken to secure reimbursement for these cases from the United States Veterans' Administration, and to see that in the future this procedure is followed with respect to each veteran who is admitted to a State hospital.

To carry the above recommendations into effect would add very little expense to the budget, but it would provide a businesslike means of collecting funds properly due for patient care. It is believed that the savings to the State as the result of the adoption of such a system would be substantial, and would enable the Department to put into effect some of the recommendations made in other chapters of this Report, with no additional net expense to the State.

CHAPTER VI

ACCOUNTING RECORDS, METHODS, AND PROCEDURES

Throughout the entire Department there is a recognition that cumbersome routines have developed over the years which have required the use of manpower and the expenditure of effort by persons in executive positions without the expected compensating benefits. Business office procedures and most accounting practices seemingly are based on the theory that "red tape" in sufficient quantity will eliminate the possibility of defalcations and provide needed "control" over the financial activities of the Department. Questions directed to staff members in the Department concerning the purpose and value of certain procedures, records, and reports frequently met with the answer, "It has been done this way for the past twenty or thirty years."

The Commission retained a firm of certified public accountants with long experience in the auditing of hospitals and in the installation of accounting systems for similar institutions to make a thorough study of the accounting operations of the Department. The report rendered by the public accountants, copies of which have been forwarded to the Commissioner of the Department of Mental Hygiene and to the Comptroller of the State of New York, is lengthy and somewhat technical in nature. It does not seem necessary in this report to enter into all the matters covered by the report of the accountants but attention should be called to matters of major importance contained in their report. Their investigation of business office and accounting procedures revealed:

1. A failure to establish to a proper degree "internal controls" over revenue, expenditures, and funds handled by the various institutions in the Department.
2. Lack of effective supervision over the general policies and procedures which govern the keeping of accounting records in the various institutions and lack of centralized control with respect to certain phases of accounting now being done in the various institutions.
3. Unnecessary duplication of accounting work on the part of individual institutions and the Albany Office.
4. The maintenance of unnecessary records, installed during the past twenty or thirty years, requiring a tremendous expenditure of time and effort with little or no corresponding benefits.
5. A tendency toward hand bookkeeping, whereas bookkeeping machines could be employed to increase office efficiency, establish desired controls, and effect savings in personnel time.
6. Lack of annual audits of financial transactions and failure on the part of the Albany Office to give effect to recommendations included in reports rendered by the Department of Audit and Control.

At present each institution operates as an autonomous unit with regard to its business procedures and accounting records and comparatively little control is exercised over these matters by the Albany Office. The financial affairs of the Department may be subject to a better degree of control by effecting a centralization of certain accounting records in the Albany Office.

Reimbursement Receipts

At present patients' ledger accounts, in which are recorded charges for maintenance and payments made, are kept in each institution and no control is exercised by the Albany Office over the outstanding balances due the various institutions. Even when the accounting records are well maintained it was found that when payments are received for the accounts of patients, the business office merely receipts and returns the patients' bills. No formal receipts are issued. A proper procedure would be to require the cashier to issue special pre-numbered receipts for all cash received, a carbon copy of which would remain in the business office for audit purposes.

Under the present system whereby each institution maintains its own patients' receivable records, defalcations of patients' receipts may occur and not be detected since the charges to patients' accounts, collection of cash, and the mailing of statements is transacted in the business office in each institution and in some instances by the same individual.

Considering the fact that receivables for patients' care in the fiscal year ending June 30, 1942 amounted to $2,782,687.45, it would appear desirable for the Albany office to have control over all reimbursing receipts. This could be accomplished by having all accounts receivable records maintained in Albany. Checks and money orders in payment of patients' bills would be mailed directly to Albany and statements of unpaid balances, etc., would be forwarded to the responsible individuals at periodic intervals. The work of posting charges and credits to patients' ledger accounts would be handled much more efficiently and economically on accounting machines. The proper equipment would provide accounting safeguards and produce uniform records. Also, the matter of follow-up on delinquent accounts would be expedited by having such records in the Albany Office, since unpaid balances could be readily referred to the attention of the proper agent in the Reimbursement Bureau.

Patients' Cash Fund

In every State hospital it is customary to accept cash from relatives and friends of patients which is to be held by the institution and used for the patients' benefit. In some hospitals, the administration permits nurses and orderlies to accept such payments from visitors with the understanding that the monies will be subsequently transmitted to the business office. It is believed that the

practice of permitting employees to accept cash on behalf of patients should be eliminated and that a General Order be issued prohibiting the acceptance of such cash except in the business office, at which point a formal receipt prepared in duplicate should be issued.

In some institutions this policy has been followed but no administrative ruling has been made which would effect a uniform policy throughout the State system.

Community Stores

Community Stores are operated in many institutions in which are sold candy, notions, tobacco, cigarettes, soft drinks, toilet articles, etc. The revenue from sales in some hospitals amounts to over $175,000 per year. Receipts are in the custody of the Superintendent and Steward at each institution. Disbursements for and on behalf of such stores are made directly by the Steward and are not subject to the approval of the Commissioner nor are they controlled by the Division of Standards and Purchase.

Profits derived from the operation of such projects are expended by institutions for various purposes such as the purchase of equipment, financing of special recreational activities for patients, payment of extra wages to employees, etc. Such special expenditures are subject to the approval of the Commissioner.

In some institutions Community Store receipts were not satisfactorily controlled by the business office nor was there adequate control over the inventory of merchandise and stock on hand.

It can readily be seen that in the handling of small merchandise items to the extent noted, a considerable inventory loss would be experienced unless proper safeguards were installed to guard against such contingency. It would appear desirable to have the Department of Audit and Control install uniform accounting systems for all Community Stores, setting up policies and procedures which would insure to the fullest extent a satisfactory accounting for all cash received and disbursed for such projects, as well as necessary accounting control over inventory of stock. Furthermore, all hospitals operating such stores should be required to submit a detailed report monthly to the Commissioner covering receipts and disbursements. This is not being done at present.

Occupational Therapy Funds

Money derived from the sale of products manufactured by patients in the occupational therapy classes is controlled by the Superintendent and Steward at the various institutions and is used to purchase supplies for the Occupational Therapy Department and on occasion the funds are also used for the purchase of equipment needed by the institution. As in the case of the Community Store, no fixed policies regulate the procedures relating to record keeping, sales, and inventory control over occupational therapy products. In many cases the person in charge of the operations

of this Department is also accountable for the receipts from articles sold, as well as the actual inventory of products manufactured.

The business office of each institution should be responsible for maintaining records and special controls over the activities of this Department. It is recommended that an administrative order be issued outlining the accounting practice and procedure to be followed with regard to the handling and recording of all receipts and disbursements so that such items may be controlled in a uniform manner in all institutions.

Colony Funds

In some of the State schools colonies are maintained for patients who are able to accept outside employment but who are not considered sufficiently improved to be placed on parole. Such patients report to their employer during the day and are required to return to the colony at night. Employers are required to pay the wages of such patients directly to the colony supervisor who keeps a special record of each patient's earnings.

It was found on investigation that the sum total of the balances earned by colony patients as per the records of account was greatly in excess of the balance of cash actually on hand in the General Colony Fund. This situation exists for the reason that certain disbursements made out of the colony fund are not for the specific benefit of certain individuals but for general operating purposes, so that it is not possible to "charge" the patients' earnings accounts.

Section 127 of the Mental Hygiene Law reads as follows:

> "The Commissioner shall make rules from time to time in respect to the disposition of such earnings and as to what portion if any shall be paid to the State as maintenance reimbursement and as to what portion, if any, shall be paid to the inmate earning such wages or compensation or set aside for the use or benefit of such inmate and what portion, if any, may be used for the common benefit of the inmates of the institution or of the colony to which the inmate is assigned. Upon discharge from the institution of any inmate having a balance of earnings to his credit the Superintendent shall determine whether such balance shall be immediately paid over to such discharged inmate or his guardian or shall be held in trust by the deputy treasurer until such time as in the judgment of the Superintendent on authorization by the Commissioner it would serve the best interests of such inmate to pay to him or to his guardian such balance or any part thereof."

According to this section the Commissioner has the right to approve the expenditure of colony funds for purposes which would benefit the inmates of the institution or the colony. The section also stipulates, however, that upon discharge from the institution

an inmate is entitled to the unexpended balance of earnings which appear in his account on the books.

The present method of accounting for earnings of colony patients results in a situation whereby the actual amounts due such patients per the records actually exceed the balance of cash on hand. Either a change in accounting procedure or a change in policy should be effected so that the records do not reflect liabilities to which the State does not admit. As a matter of principle, it would appear desirable for a ruling to be issued which would prohibit the use of colony funds for purposes other than actual expenditures made specifically for or on behalf of patients and a charge at a fixed rate for maintenance of the patients.

Accounting Control of Supplies

The keeping of perpetual inventory records for the purpose of controlling supplies is, of course, extremely desirable, but only if carried on in such a manner that the desired safeguards are obtained. Every institution keeps perpetual inventory records for the purpose of controlling merchandise in storerooms. These records are maintained on a quantity basis only. Policies concerning the keeping of such records are determined by the Steward in each institution and in a number of hospitals it was evident that the records were kept mainly to comply with a "general order" rather than to establish a safeguard over merchandise and stock on hand. In some institutions the storekeeper has free access to the inventory records which reduces to a great extent the value of the inventory control since shortages may be "adjusted" on the accounts by the very person responsible for the safekeeping of supplies. It was also found that in some hospitals the inventory records were not used by the Steward to check the quantity of supplies that should be in the storerooms.

Consideration may well be given to the keeping of perpetual inventory records both as to the quantity and value of supplies received and disbursed. Under this system, shortages would have to be recorded on the books, whereas under the present procedure, since only the "quantity" of stock received and issued is recorded, no entries need be made on the books to reflect in dollars the amount of shortages or inventory adjustments. A record of the value of stock issued would also enable institutions to charge various departments with the cost of supplies requisitioned. This is not being done under the present system.

Payroll Procedures

Over 15,500 individuals are now employed in the institutions operated by the Department of Mental Hygiene so that the preparation of payrolls is an involved and time-consuming task. At present the payrolls for the entire Department are prepared in the Comptroller's Department. All employees are paid semi-monthly and receive pay checks five days after the end of a payroll period.

Since the Comptroller's office requires a period of nine to ten days to prepare the payrolls and since it is necessary to devote a few days' time to the task of noting payroll adjustments in each institution, payroll information is now actually assembled about nine or ten days before the end of each payroll period. Checks are drawn on the basis of this information and as a result a great many checks have to be returned every pay day because of resignations, payroll removals, and other adjustments which occur from the date the payroll information is sent to the Comptroller and before the end of the payroll period.

The Comptroller's Office uses tabulating punch cards to prepare payroll sheets, earnings records, and checks. Insufficient staff makes it impossible for this office to keep information regarding withholding tax deductions so that this data must be kept by each institution.

The present methods and procedures relating to payroll disbursements are the result of legislation which requires a "pre-audit" of every disbursement of State funds. Prior to the enactment of this legislation, all payrolls were prepared and checks were drawn and issued by the business office of each State institution. The present system is cumbersome and unsound from the standpoint of the control of funds and is not, in fact, a "pre-audit." The very fact that payroll checks need to be drawn on information prepared approximately ten days before the end of a payroll period of itself reveals the lack of control the State is able to exercise over payroll disbursements for this Department. This situation leaves the door open to possible fraud in that many payroll checks are distributed to the institutions which are drawn for a sum in excess of actual salaries earned. The necessity of having to return many of the checks drawn because of changes taking place after the payroll schedule is prepared causes a great deal of unnecessary work and must in many instances prove inconvenient to employees of the Department. There is no ready way of determining whether all such checks are returned for correction.

If the pre-audit legislation were to be carried out as apparently intended, no institution would be required to submit its requisition for payroll checks prior to the end of a payroll period. If this were done, however, it would not be possible to pay employees for a period of approximately fifteen days after the payroll period has elapsed.

Probably the most satisfactory manner to handle payrolls in a Department as large as Mental Hygiene would be to restore the work of preparing payrolls to the individual institutions and provide them with mechanical equipment which would enable the business office to prepare in one operation a payroll check, employee's earnings record, and duplicate copies of a master payroll sheet. One copy of this payroll record could be sent to Albany for the approval of the Civil Service Commission and the Comptroller, thereby satisfying the "pre-audit" requirements, whereupon a check could be drawn for the exact amount of the

payroll and deposited in a special bank account against which the payroll checks would be issued.

Quarterly Estimate

For over twenty years the Department of Mental Hygiene has attempted to control the expenditures of various institutions by having each hospital submit an estimate of all anticipated expenses in advance of each quarter of the year. This information is submitted in considerable detail showing by items the quantity, price, and total cost of every type of expenditure the institutions plan to incur during the ensuing quarter. After the Quarterly Estimate is checked and approved by the Commissioner, it constitutes authorization to incur the expenditures listed and institutions may issue purchase orders covering such items regardless of actual need.

A Quarterly Estimate for any institution consists of from seven hundred to eight hundred pages and must be typed in quadruplicate. It has been estimated that, without considering the time involved in checking this record in the Albany Office, from one thousand to fourteen hundred days of work are involved just to prepare this information.

The Division of Standards and Purchase as well as the Department of Audit and Control has favored the discontinuance of this record. Legislation was introduced in 1942 which would have relieved the institutions of the need for its continuance but was not enacted as a result of objections raised by the former Commissioner of the Department of Mental Hygiene.

It is extremely difficult to obtain a statement from anyone in the Department which would indicate the need and value of such information. Officers in the Albany Office stated that a number of hospitals, when preparing the Quarterly Estimates, merely copied the items which appeared in previous estimates. This is not surprising since it is probably next to impossible for any administrator or business manager to anticipate the exact needs of an institution for a period of four and a half months. Furthermore, it is believed that this method of limiting expenditure tends to destroy initiative and undoubtedly encourages the "padding" of expenses and supplies for which approval is requested.

With adequate accounting records which would show the relation of actual expenditures and commitments to the budget appropriations, it would be possible to control month by month the operating expenses of each institution without resorting to the "red tape" which now exists with regard to the preparation of Quarterly Estimates.

Use of Accounting Machines for Recording Budgetary Expenditures

Should the Department of Mental Hygiene discontinue the use of "Quarterly Estimates," it would be necessary to substitute a record which would provide adequate financial information regard-

ing the relationship of actual expenditures to budget appropriations.

At present, this information which involves a needless duplication of work, is kept by hand by both the Albany Office and each institution.

Recommendations have been made in the Accountants' report for the elimination of certain records which are now duplicated within the Department. The use of special bookkeeping machines would enable the Albany Office to keep accounting records of expenditures for all institutions showing with relation to each budget appropriation:

1. Total appropriation
2. Amount of warrants issued and paid
3. Amount of unpaid orders and purchase vouchers
4. Unencumbered balance of budget appropriation

The above record is known as an "Encumbrance Ledger" or "Appropriation Ledger" and a special budget report could be prepared in duplicate from this ledger for each institution, one copy of which could be forwarded to the institution at the end of each month, thus relieving them of the need for keeping the Quarterly Estimate, Cost Distribution Book, and Voucher Register.

For many years the Federal Government, as well as state and city agencies, have successfully engaged the use of accounting machines for the purpose of maintaining an "Appropriations Ledger" and there is no reason why a similar system would not function efficiently for the Department of Mental Hygiene.

Audit of Financial Transactions

The Department of Mental Hygiene does not maintain auditors on its staff charged with the responsibility of verifying and checking the accuracy of the records kept by its various affiliated institutions. An audit of financial transactions appearing on the books of various institutions is made by the Department of Audit and Control and we were advised by the Director of Mental Hygiene Accounts that the records of only nine institutions were audited from January 1, 1942 to November 30, 1943 by the Department of Audit and Control. Some of the audits covered a period of five years and the average "audit period" for the nine reports rendered was three years.

Considering the tremendous amount expended in the operations of these units, as well as the large amount of receipts which are handled during the course of a year, more frequent audits should be made. An annual audit of every institution would certainly seem justified under the circumstances and it is recommended that such a program be put into effect as soon as possible.

Audit reports prepared by the Department of Audit and Control were reviewed and indicated that a thorough examination of the institutions' records had been made. Many valuable recommendations were incorporated in these reports regarding changes in

accounting procedure which apparently were completely disregarded by former Commissioners. Unless the suggestions and recommendations are acted upon by the Commissioner, a financial investigation is meaningless and complaisance on the part of the Department in the past toward poor accounting procedures has resulted in a lowering of the standards throughout the system.

General

The purpose of this section is to relate briefly a few of the accounting problems which were encountered during the course of this investigation. Aside from the seemingly undue waste of time and effort in the keeping of duplicate records and the retention of records which are of questionable value, the lack of centralized control and understanding of the business procedures as carried on in the various institutions present matters which should be of immediate concern to the Department. In some of the institutions great care is exercised in the keeping of financial records and it is apparent that the individual in charge understood thoroughly the need for good accounting and business methods. On the other hand, a large number of hospital units are failing to exercise sound procedures in their business office, yet until recently little or nothing has been done to correct the situation by the Albany Office.

The report of the accountants retained by the Commission includes specific recommendations relative to all of the subjects touched upon in this chapter. It is evident that the accounting and business procedures in the Albany Office, as well as in the various institutions, should be revised for the purpose of eliminating all unnecessary record keeping and providing, instead, needed and essential financial data which may be used both in the administration of a particular institution, as well as for the purpose of controlling the expeditures of the Department as a whole.

CHAPTER VII

ADMISSION, DISCHARGE, PAROLE, AND FAMILY CARE

Curtailment of Unnecessary Load on the State Hospitals

According to the last (1939) publication of the United States Public Health Service on Public Mental Hospitals, New York State has the largest number of mental patients of any state in the Union and the highest hospitalization rate per 100,000 of population (727.0) except Massachusetts (757.0) and the District of Columbia (1296.2).

The 1942 report of the Department of Mental Hygiene shows that according to the local residence of patients on the books of the Civil State Hospitals, the largest number, 23,212 were from New York County, representing a ratio to 100,000 population of 1,224.9. This ratio is almost twice that of the next county (Kings) —618.5. The average ratio for all counties was 607.1.

First admissions from the five metropolitan counties, Bronx, Kings, New York, Queens, and Richmond, totalled 8,867; from all other counties 4,871, or 64.5 per cent and 35.5 per cent respectively, of all first admissions. Of the total on the books of the State hospitals, 53,459 or 64.3 per cent were from the metropolitan counties, while 29,594 or 35.7 per cent were from the remaining counties. Of the 17,611 admissions and readmissions to the State mental hospitals in 1942, 8,979 were from Bellevue Hospital, 50.9 per cent of the total.[1]

As of October 1, 1943 the certified capacity of the Civil State Hospitals was 62,941. The actual number of patients in residence was 72,191. The excess over capacity was at that date 9,370 or 15 per cent. In the State schools for mental defectives the overcrowding was 20 per cent and at Craig Colony the overcrowding was 11.6 per cent. There is no question but that the State institutions are full to over-flowing.

Notwithstanding the overcrowded conditions of the State hospitals and of the institutions for mental defectives, part of Pilgrim State Hospital and part of Rockland State Hospital and Willowbrook State School in its entirety have been turned over to the United States Army for use as military hospitals. These buildings were in large part recently constructed in order to relieve the overcrowding in the institutions of this Department. During the war and probably for some time thereafter they will not be available for this purpose.

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[1] Except for the excellent work of diagnosis and segregation done at Bellevue Hospital the admissions to the State hospitals would undoubtedly be higher. In the year 1942, 29,480 persons went through the Psychopathic Division of this hospital, of whom 8,979 were committed to State hospitals. Of those committed to State hospitals approximately one-third were senile or arteriosclerotic.

The following table shows the percentage of overcrowding in the institutions as well as the actual numbers under care as of October 1, 1943:

State Institutions	Patients					Excess of Patients over Capacity	
	Census including parole	Number in institutions *	Number in family care	Number on parole	Certified capacity	Number	Percent
State Hospitals:							
Binghamton	2,976	2,653	71	252	2,391	262	11.0
Brooklyn	4,489	3,337	3	1,149	2,603	734	28.2
Buffalo	2,878	2,494	25	359	1,942	552	28.4
Central Islip	8,034	7,117	91	826	6,443	674	10.5
Creedmoor	4,964	4,421	.....	543	4,142	279	6.7
Gowanda	3,075	2,605	83	387	2,228	377	16.9
Harlem Valley	4,760	4,368	105	287	3,972	396	10.0
Hudson River	5,180	4,818	102	260	4,131	687	16.6
Kings Park	7,203	6,269	24	910	5,390	879	16.3
Manhattan	4,256	3,616	1	639	3,616	.....	.....
Marcy	2,864	2,497	42	325	2,140	357	16.7
Middletown	3,868	3,465	221	182	2,742	723	26.4
Pilgrim	9,546	8,634	86	826	7,831	803	10.3
Psychiatric Institute and Hospital	133	127	.....	6	210	83	.....
Rochester	3,466	3,075	70	321	2,740	335	12.2
Rockland	6,770	5,855	52	863	4,700	1,155	24.6
St. Lawrence	2,269	1,967	97	205	1,721	246	14.3
Syracuse Psychopathic Hospital	26	26	.....	.....	60	34	.....
Utica	2,068	1,773	65	230	1,552	221	14.2
Willard	3,143	2,926	65	152	2,431	495	20.4
Total	82,072	72,191	1,154	8,727	62,941	9,370†	15.0†
State Schools for Mental Defectives:							
Letchworth Village	4,723	4,095	211	417	3,178	917	28.9
Newark	3,147	2,519	226	402	1,874	491	26.2
Rome	3,969	3,506	.....	463	2,440	236	9.7
Syracuse	1,344	946	.....	398	677	118	.....
Wassaic	4,868	4,389	131	348	3,544	821	23.2
Total	18,051	15,455	568	2,028	11,713	2,347	20.0
Craig Colony for Epileptics	2,399	2,220	.....	179	1,990	230	11.6

* Including colonies.
† Excluding Psychiatric Institute and Syracuse Psychopathic Hospital.

With the demand for care in the mental hospitals growing out of all proportion to the increase in population, a determination must be reached as to a future program for the care of the mentally ill. In the past the increasing numbers have been accommodated by the relatively easy, though expensive, expedient of building more hospitals. Within limits, hospital accommodation must be provided. However, before the State is committed to the support of an expanded system of new institutions, the possibility of other solutions to the problem of the care of the mentally ill should be explored. It goes without saying that any such solutions should not sacrifice the quality of care given to patients.

Obviously if the load on the hospitals is to be reduced, four methods must be considered to accomplish that purpose:

(a) restricting admission of patients who do not need the special type of care rendered by mental hospitals or who can be cared for equally well elsewhere;

(b) transferring to appropriate agencies cases for which the State of New York should not bear the responsibility, such as residents of other states, aliens, veterans;

(c) discharge of such patients as reasonably can be expected to become adjusted to life outside an institution through intensified methods of treatment in the hospital and by the use of parole, family and colony care;

(d) preventing serious mental illness by early detection, diagnosis, and treatment.

(a) Restricting Admission of Patients Who Do Not Need the Special Type of Care Rendered by Mental Hospitals or Who Can Be Cared for Equally Well Elsewhere

The great influx of the aged into the State hospitals since the days of the depression has been due not so much to mental ills on their part as to an unwillingness by the local communities and the families to take care of those who are merely suffering from the natural consequences of old age. All too often a patient with some mental symptoms resulting solely from age is committed to a State institution. Twenty-two per cent of all first admissions to State hospitals in 1942 were of persons over the age of seventy. This constantly increasing influx into the State mental hospitals of patients who are senile or who have cerebral arteriosclerosis raises a question as to whether many of them are in need of such care as is provided in the mental hospitals.

Senile psychoses and cerebral arteriosclerosis in the last thirty years have risen from 13.5 per cent of first admissions to 35.4 per cent. The senile and arteriosclerotic patients on the books of the State hospitals represent 11 per cent of the total number. The apparent discrepancy between the percentage of admissions and the percentage in the hospitals is accounted for by the fact that the average stay in the hospital of these patients until death is only a year and a half, many of the deaths, in fact, occurring within a few days after admission.

A comparison of admissions, number in hospital, and length of hospital stay of types of principal mental disorders is:

	Percent of First Admissions July 1, 1941–June 30, 1942	Percent of Hospital Population June 30, 1942	Average Length of Hospital Stay—Yrs.
Cerebral Arteriosclerosis ...	23.0	7.5	1.6
Senile Psychoses	12.4	3.8	1.5
Dementia Praecox	24.2	58.0	19.3
Manic Depressive	5.0	6.3	7.3
Alcoholic	6.6	2.9	7.1
General Paresis	5.6	5.0	3.6
Paranoia	0.6	1.4	21.1

Many of the senile and arteriosclerotic people sent to State hospitals are merely confused and unable to take care of themselves. Nothing can be done for most of them other than to make them comfortable and give them simple medical and nursing care. Such care is custodial rather than curative. The problem is primarily one of the care of the aged rather than one of treatment of the mentally ill.

A survey was made by the Commission in two hospitals to determine what percentage of the senile and cerebral arteriosclerosis groups in those hospitals were no longer in need of State hospital care and should no longer be in a mental hospital. The hospitals selected were Harlem Valley and Manhattan. The survey of cases was made by the staff of the Commission with the collaboration of Dr. John H. Travis and Dr. Harry A. LaBurt, Superintendents, respectively, of Manhattan State Hospital and Harlem Valley State Hospital, together with members of their medical staffs.

The selection of cases was confined to the groups diagnosed as senile and cerebral arteriosclerotic. The aged of other diagnostic classifications were excluded. Both bed and ambulatory cases were included. Any questionable case was given the benefit of the doubt and considered as requiring further mental hospital treatment.

The following is a tabulation of the results of the study:

Study of Senile and Arteriosclerotic Groups at Two State Hospitals—October 27–28 and November 9–16, 1943

1. Harlem Valley State Hospital	Found not in need of Mental Hospital Care		Found in need of Mental Hospital Care		
	Male	Female	Male	Female	Total
Senile	14	39	14	34	101
Cerebral arteriosclerotic	49	72	50	53	224
Total	63	111	64	87	325

Total found not needing mental hospital care — 174 or 53.5%.

2. Manhattan State Hospital	Found not in need of Mental Hospital Care		Found in need of Mental Hospital Care		
	Male	Female	Male	Female	Total
Senile	44	91	20	104	259
Cerebral arteriosclerotic	147	228	76	204	655
Total	191	319	96	308	914

Total found not needing mental hospital care — 510 or 55.7%.

The presence of these people in the State hospitals is against the desire of these hospitals to keep them, and is because of the fact that there is no other place prepared to receive them.

Under Section 87 of the Mental Hygiene Law, a Superintendent may discharge a patient who has not recovered but whose discharge

in his opinion will not be detrimental to the public welfare or injurious to the patient. This section, however, provides that before discharging such a patient "the Superintendent shall satisfy himself by sufficient proof that friends or relatives of the patient are willing and financially able to receive and properly care for such patient after his discharge." The section also provides that a poor and indigent patient discharged by the Superintendent because he is not insane "shall be received and cared for by the Commissioner of Public Welfare or other authority having similar powers in the county from which he was committed." The difficulty in discharging senile and arteriosclerotic patients is that the Commissioners of Public Welfare refuse to take them on the ground that they have a record of commitment to a State institution and their families either refuse or are unable to receive and care for them.

County homes and old folks' homes, as a rule, refuse to accept persons who have a history of mental disturbance even though this mental disturbance is only an incident to old age. As a result, thousands of persons who have reached old age and are mentally suffering from the effects of advanced years find themselves in what they themselves regard as "insane asylums" and the families find themselves regarded as having "insanity" in the family.

The following table shows the number of patients admitted and the number under care of the combined groups diagnosed as senile and as cerebral arteriosclerotic in each of the State mental hospitals for the fiscal year ending June 30, 1942.

Senile and Arteriosclerotic—State Mental Hospitals Percentage of Admissions and of Hospital Population

	Admissions			In Hospital		
Hospital	Total	Number S. & A.	Percentage S. & A.	Total	Number S. & A.	Percentage S. & A.
Binghamton	402	133	33	2,750	269	9.7
Brooklyn	2,537	1,092	43	3,401	1,051	30.0
Buffalo	530	223	42	2,457	317	12.9
Central Islip	1,053	287	27	7,196	738	10.2
Creedmoor	907	356	39	4,611	567	12.3
Gowanda	415	109	26	2,367	202	8.6
Harlem Valley	368	128	34	4,508	342	7.5
Hudson River	439	187	42	4,549	531	11.6
Kings Park	841	148	17	6,392	389	6.1
Manhattan	1,352	816	61	3,119	722	23.1
Marcy	505	184	36	2,489	234	9.4
Middletown	232	79	34	3,328	228	6.8
Pilgrim	1,227	322	26	8,972	954	10.6
Rochester	464	177	38	3,144	306	9.7
Rockland	1,265	278	22	6,902	749	10.8
St. Lawrence	296	88	29	1,991	122	6.1
Utica	376	135	36	1,775	220	12.3
Willard	298	116	38	3,022	326	10.7

The foregoing table shows that during the fiscal year ending June 30, 1942, 8,267 patients with the diagnosis of senility and

cerebral arteriosclerosis were under care in the State mental hospitals. If it were true of all the hospitals as it is in Harlem Valley and Manhattan State that at least one-half of this number were not now in need of care such as is provided in a mental hospital and if these patients were discharged, over 4,000 beds would be available to relieve conditions of overcrowding. This is the equivalent of a hospital the size of Harlem Valley State Hospital.

So long as no adequate provision is made by the local communities for the aged, just so long will the State mental hospital be considered both by their relatives and the local communities as a convenient "dumping ground" for them. The result will follow that the State hospitals will become in effect old folks' homes rather than hospitals in the true sense of the word. Until the State refuses to allow the mental hospitals to be used as old folks' homes, just so long will the State hospitals fail fully to achieve the status of primarily curative hospitals.

This problem of taking care of the indigent chronically ill, including those suffering from the natural consequences of old age, is a broad social problem. It involves much more than the mental hospitals. It is closely related to the problem of the care of chronic illness, a field of social responsibility almost as much neglected today as mental illness was a hundred years ago. There is a need today for the establishment of a long range program shared by the State, the counties, and the cities to provide care for this group of citizens. Such a program would do much to solve the problem of overcrowding in the mental hospitals and at much less expense to the State than the building of new mental hospitals. The development of such a program would go far beyond the authority and resources of this Commission. It is a matter which should be studied in itself with reference to the care of the chronically ill and incapacitated of all ages. The State of New York should lead the way in meeting this problem.

Until some adequate arrangements are made for taking care of the senile and arteriosclerotic, the problem of overcrowding in the State hospitals will remain acute. As a recommendation for immediate action, it is urged that the Mental Hygiene Law be amended to provide that the Department of Mental Hygiene shall be notified of all applications for commitment to a State institution with the right to appear and present reasons of the Department in opposition to the application for commitment. In this way, to some extent, the Department will be enabled on the commitment proceedings to refuse to accept some of those patients who properly should be cared for elsewhere.

(b) Transferring to Appropriate Agencies Cases for Which the State of New York Should not Bear the Responsibility, Such as Residents of Other States, Aliens and Veterans

The removal of non-residents of New York State has always posed difficult problems. For the year ending June 30, 1942 there were

removed from the New York institutions eight hundred and ninety-three patients who, according to the records of the Department, were not legally residents of the State. It is almost impossible at times to determine legal residence and often when it is ascertained, other states refuse to accept the return of a patient.

The removal of deportable aliens is one that will have to wait until the end of the war. Of the 13,738 first admissions in the fiscal year ending June 30, 1942, 4,796 or 34 per cent were foreign born patients. Of this number 1,805 were aliens. In other words, 13 per cent of the patients admitted were not even citizens. However, of the foreign born including aliens, only one hundred and sixty-seven had been residents of the United States for less than ten years. As soon as war conditions permit, arrangements should be made for the removal of deportable aliens afflicted with mental illness.

With respect to veterans the State should not have to carry the burden of their care, especially since the Federal Government maintains its own mental hospitals. This problem will become increasingly acute after the present war. As is shown in the chapter on Reimbursement for Patient Care, there has admittedly been little attention given even to the problem of securing reimbursement from the Federal Government for cases of veterans committed to the New York hospitals. This has been the result of the inertia and lack of organization of the Commissioner's office. Prompt rearrangement of the procedure with reference to determination of the Federal Government's liability on cases of commitment of veterans is imperatively needed.

(c) Discharge of such Patients as Reasonably Can Be Expected to Become Adjusted to Life Outside an Institution

(1) *Intensified Treatment.* During the last twenty years admissions to State hospitals for dementia praecox have constituted, with little variation, one-fourth of all admissions. Dementia praecox is the most frequently occurring mental condition requiring hospital care. For the fiscal year ending June 30, 1942, dementia praecox accounted for 24.2 per cent of the admissions and 58 per cent of the in-patient population of the State mental hospitals. Unlike the patients with senile psychoses and cerebral arteriosclerosis, those with dementia praecox are young people and their average stay in hospitals is 19.3 years. They grow old in the hospitals and constitute over half of the number of patients under care, and are five times more numerous than the next largest group, the senile and arteriosclerotic. Patients with dementia praecox require care in a mental hospital and their mental condition is one that does not respond readily to curative measures although shock treatment has been followed by good results in an increasing percentage of cases. Since the group of dementia praecox cases represents more than the combined total of all other types of mental disorder, the importance of

utilizing shock therapy to the greatest possible extent is evident. Hope for the dementia praecox patient lies, besides shock therapy, in the discovery of the cause of his condition and in finding new and more effective methods of treatment.

Manic-depressive psychosis is responsible for only 5 per cent of first admissions to the State mental hospitals (fiscal year ending June 30, 1942) whereas twenty years ago it accounted for 14.2 per cent. Shock therapy for this type of mental disorder has given encouraging results.

General paresis has shown a marked decline as a cause for treatment in the State mental hospitals—for the fiscal year ending June 30, 1923, 11.8 percent of first admissions were for general paresis whereas for the year ending June 30, 1942 the percentage dropped to 5.6. The decline in the incidence of general paresis is attributable to improved methods of control and treatment of syphilis, the cause of the disease.

(2) *Parole.* Next to the prevention of mental disorders, the restoration to mental health, thereby enabling patients to resume their places in society, holds out the best prospect for minimizing the need for expansion of State hospital facilities.

The percentage of patients on parole of the total number of patients under care has increased slowly in the last ten years, from 7.5 at the close of the fiscal year 1933 to 10.4 in 1942 for the State hospitals and from 7.5 to 12.3 in the same period for the State schools. In explanation of the more than average rise in paroles in the hospitals for 1942 as compared with the preceding year (10.4 against 9.3), the Report of the Department for the fiscal year ending June 30, 1942 states that "the relatively large increase in 1942 was due, however, to special efforts to increase the number of patients on parole." Coinciding with the study of the Temporary Commission on State Hospital Problems of the subject of Parole, the inference is justified that the "special efforts" were inspired by activity outside the Department and were not the result of spontaneous interest within it.

There has been no well defined policy or procedure with respect to parole in the State hospitals. There is no periodic review of all cases, recommendation for parole being left to the judgment of various ward physicians in the hospitals. It is the opinion of this Commission that "special efforts" should be made continuously in the institutions to find patients suitable for parole and that the Assistant Commissioner in charge of the Division of Medical Service should be responsible for supervising and stimulating the function of parole throughout all the State mental institutions. The present number of physicians is insufficient to examine into the parole status of each patient. That such a supervision of parole is necessary is indicated by the fact that there is a great variation in policy among the institutions, the percentage of paroles running from 5.2 to 24.2. Only four hospitals were above 12 per cent, Brooklyn, Rockland, Buffalo, and Gowanda. If the average of all hospitals were 12 per cent, it would mean an annual saving to the State of over half a million dollars.

In the different hospitals there is also a wide variation in the ratio of patients discharged as recovered, from 9.1 per 100 admissions at Harlem Valley to 34.3 per 100 admissions at St. Lawrence. This variation in rates of recovery is only partly explained by differences in the types of patients received by the hospitals.

Another factor bearing on the subject of parole and discharge is the readmission rate. For the fiscal year ending June 30, 1942, there was a total of 17,611 admissions of which 3,873 or 22 per cent were readmissions. A high readmission rate is to be expected unless patients are able to adjust themselves in society after parole or discharge from the institutions. One reason for failure to make adjustments is that patients are frequently returned to surroundings which may have contributed largely to their mental breakdown in the first place and, without help, they relapse into their former mental conditions.

Any system of parole, therefore, to attain maximum success requires not only that patients be sufficiently recovered but also that they be placed in environments conducive to their continued ability to adjust themselves to life as members of society. Such an ability to readjust is greatly augmented by adequate medical and social follow-up and supervision. The extent of this follow-up and supervision is dependent to a great extent upon an adequate staff of psychiatric social workers. The discussion of this problem and the recommendations made with reference thereto in the chapter on Professional Care of Patients must also be considered in connection with any consideration of the adequacy of parole procedures.

(3) *Family Care.* "Boarding out" of mental patients in family homes is nothing new. It was practiced by Massachusetts almost sixty years ago but only to a limited extent. It was authorized by the New York Legislature in 1935 and an allotment of $20,000 to each State hospital was made for the purpose. The law, however, limited the rate to be paid for family care to a sum not exceeding $4 per week. Subsequently, in 1940, the Legislature increased the allowable rate to $6 per week and in 1942 further amended the law by removing the limit on the rate to be paid. In that year the Department authorized the payment up to $7 per week plus 25 cents per week for spending money per patient. In April 1943, the allowable rate was again increased by the Department to $8. According to the records of the Department, for the six months from April 1, 1943 to September 30, 1943, the average weekly payment for family care was $6.99, the range being from $5.13 to $8.19.

The direct cost of care in the mental hospitals for the fiscal year ending June 30, 1942 was $401.46 per patient or $7.72 per week. These figures do not include indirect costs, interest on investment, depreciation, capital outlay, central office expense, or payment to the retirement fund. While the cost of $6.99 for family care does not include medical and social service supervision, it is apparent that family care is less expensive than institutional care and even if it were not, the more patients that can be cared for by

family care the less need there is for capital expenditures for additional institutions. It is estimated that new hospital construction requires an expenditure by the State of approximately $2,500 for every patient.

The success of family care is measured by the ability of patients to stay out of the institution and their ability to do so is greatly increased by continued psychiatric care and social service supervision. Such care and supervision to date have been inadequate chiefly because of the lack of psychiatric social workers resulting in impossible case-loads.

At the end of the fiscal year ending June 30, 1937, the first in which family care was utilized, there were three hundred and seventy-seven state hospital patients receiving such care. In 1940, because of a retrenchment program ordered by Governor Lehman, many State hospital patients in family care were recalled to the hospitals in the interests of "economy," only two hundred and nine being in family care at the end of the year. At the end of the 1942 fiscal year, however, the number had increased to 1,256 and at October 1, 1943 there was a total in family care of 1,722.

(4) *Colony Care.* Another possibility for relieving the pressure on the mental hospitals which seem worthy of a practical trial, especially in areas where suitable homes for family care are not available, is a plan for colony care similar to that now operated so successfully for mental defectives by three of the State schools.

As conditioning for such colony life and for parole, supervised but not regimented life in certain buildings for selected groups of patients would appear to be a feasible transitional procedure. At several of the hospitals, as a result of the law providing for cash salary additions in lieu of maintenance, there are vacant employees' quarters which could well be put to use in furnishing this type of housing for the better patients in a transition from institutional life to life in the community.

Maximum good results both with parole and family care can be expected only when there is an organized program toward that end with close supervision from the Commissioner's office and ready acceptance on the part of all the mental institutions. Such a program would require an adequate follow-up by social workers, under direction of the psychiatrists, of all patients paroled or placed in family care. Such a program has not existed in the past except to a very limited extent.

(d) Preventing Serious Mental Illness by Early Detection, Diagnosis, and Treatment

Preventing the need for care in State mental hospitals is perhaps the most hopeful means of keeping within the bounds of present hospital capacity. The program of control of tuberculosis furnishes an example of what can be accomplished in making hospital facilities less and less necessary. Tuberculosis sanatoria crowded to capacity with long waiting lists twenty years ago, now can often

take patients as fast as admission is requested. Merely providing hospital treatment for cases of tuberculosis could not have accomplished such results. Such results have been possible only because of a program of prevention and control.

As with tuberculosis, cancer, or almost any disease condition, the earlier that mental disease or tendency toward mental illness is discovered, the more hopeful is the pospect of cure. The earliest contact with potential mental patients on any large scale program of prevention is with the children in school. Child guidance clinics should be a part of every well directed system of school medical inspection with adequate follow-up visits to homes and instruction of parents. In Massachusetts the mental hygiene law requires the State hospitals to assume responsibility for school clinics.

The first signs of mental breakdown are usually seen but too often not recognized by the patient's regular medical attendant. Few physicians have had much more than casual instruction in psychiatry as medical students and relatively little experience in practice. When medical practitioners are equipped to recognize mental deviations in the early stages, their patients will frequently need less institutional care. Almost every general hospital, public and private, should, therefore, have a psychopathic unit. Such units available for the use of physicians in caring for early cases would be "filters" for the State hospitals and they would tend, measurably, to reduce the need for State hospital admissions. Private voluntary hospitals and municipal general hospitals should be encouraged by the State to establish psychiatric units and psychiatric clinics.

DISCHARGE OF PATIENTS WHO HAVE ESCAPED

General Order No. 14 of the Rules and Regulations of the Department provides that if a patient escapes and is not returned to the institution within one year after his escape he must be discharged. While the effect of this regulation may be to improve the statistical reports somewhat, it certainly fails to express the realities of the situation. The rule apparently presumes that a person sane enough to escape from the institution and remain at large for one year has recovered his sanity. Thereafter, he can be taken back into the institution only if a new order of commitment is secured. It is submitted that this order is one that should be rescinded promptly.

FINGERPRINTING OF PATIENTS

At the present time patients in mental hospitals are not fingerprinted. There is, therefore, no sure means of knowing whether a patient who is admitted to such an institution may have a criminal record or be wanted upon criminal charges. Likewise, when a patient is discharged from such an institution and later becomes involved in some criminal offense, there is no sure means whereby

the criminal authorities may learn that he formerly was confined in a mental institution. A bill was passed at the 1943 session of the Legislature, providing for fingerprinting of patients in these institutions, which had to be vetoed because of the fact that no appropriation was provided for the fingerprinting. The law should be amended to provide for the fingerprinting of patients in these institutions and necessary appropriations should be made for this purpose.

PROCEDURAL CHANGES IN ADMISSION

The Judge issuing an order of commitment now specifies the hospital to which the patient is to be sent and thereafter he can be transferred from that hospital only on order of the Commissioner. Generally speaking, the Judge is not the best qualified person to decide where patients should be sent for their own good and in the public interest. For example, certain hospitals may be better equipped to take care of certain types of cases than other hospitals or certain hospitals may be more overcrowded than others. It is recommended that the law be amended to provide that the order of the Judge shall refer the patient to the Department of Mental Hygiene and the designation of the hospital in which the patient shall be admitted shall be determined by the Department and not by the Judge. Furthermore, the law requires the Commissioner to establish districts within the State and patients may initially be admitted only to hospitals within particular districts. This provision of law is no longer needed and it would be advisable to give the Commissioner complete freedom in the matter of assignment and distribution of patients in mental hospitals.

In New York State there are five methods of commitment:

(a) On voluntary application;
(b) On certificate of health officer;
(c) On certificate of one physician;
(d) On court commitment;
(e) On incomplete court commitment to meet an emergency.

Since over three-fourths of all admissions are on court commitment, this form overshadows the other four.

The present procedure for admisssion is a hold-over from the days when mental illness was treated almost in the nature of a criminal offense. To arraign a mentally ill person before a Judge and then "commit" him to an institution smacks of criminal proceedings rather than medical treatment. The procedure is not conducive to the mental improvement of the patient. While for the protection of the individual rights of persons a court order is probably necessary, steps should be taken to remove the legalistic forms which surround the proceedings.

A commitment on a certificate of a health officer or on a certificate of one physician necessitates the patient being released within thirty days after he, or any other person on his behalf, requests

such release (Mental Hygiene Law, Secs. 72, 73). No person may be detained in a psychopathic hospital or in a psychopathic ward of a general hospital for a period longer than thirty days (Mental Hygiene Law, Sec. 81 (2)). These periods of observation appear to be too short, and the Law should be amended to allow in these cases a sixty-day period of observation, with the requirement that within the sixty days, irrespective of any application by the patient or persons on his behalf, the patient either is discharged or formal procedures are instituted for the commitment of the patient to a State mental hospital.

Furthermore, the present procedure for legal commitment to a State mental hospital presupposes that the Judge has finally determined that the patient is "insane." To impose this responsibility upon a Judge where a patient has not been in a hospital for a sufficient period of observation is to place a burden upon the Judge which is fair neither to him nor to the patient. It is believed that it would be desirable to provide that no person be finally committed to a State mental hospital unless he has been under observation in a psychopathic hospital, a psychopathic ward, or under treatment by a registered psychiatrist, so that there may be a basis of expert advice based upon a period of treatment as to whether such patient should finally be committed to a State institution. It should be pointed out that an order of commitment to a State hospital, even if followed by a discharge within a relatively short time, becomes part of the patient's life record so that at all times in the future he has a history of having once been judicially determined to be insane. To correct this situation it is recommended that the Law be amended to provide that a Judge may, in his discretion, certify a patient "for observation" to a State mental institution for a period not to exceed sixty days. Within that time the hospital should make a report on the case to the Judge and, in the event that the hospital believes on the basis of its observation that a commitment is necessary, a final hearing on the commitment could be held within or at the end of the period of observation.

To carry these suggestions into effect the Commission recommends the following:

(a) The word "commitment" should be eliminated from the law and procedure and in place thereof provision should be made for the Judge to "certify" the patient to the Department of Mental Hygiene or other appropriate agency for care and treatment.

(b) The word "parole" should be eliminated as having a criminal connotation and in place thereof there should be used the words "convalescent status."

(c) Proceedings should, to the extent possible, be held not in court houses but in hospitals. When they are held in hospitals, it is a mistake to have the room in the institution set up as a courtroom, as is now done at Bellevue Hospital. The proceedings should be informal and conducted in an atmosphere of a medical conference rather than that of a court.

(d) Throughout the text of the Mental Hygiene Law the word "insane" should be replaced by the words "mentally ill," and "insanity" by "mental illness." For the latter words, "mental disorder" may be used as a synonym.

(e) The Mental Hygiene Law should be amended to provide that a person admitted on certificate of a health officer or on certificate of one physician may be detained in a State hospital for a period up to sixty days for observation. The same provision should appear in the Mental Hygiene Law with reference to commitments to psychopathic hospitals or psychopathic wards in general hospitals.

(f) Provision should be made in the Mental Hygiene Law allowing a judge to certify a patient to a State mental hospital for observation for a period not to exceed sixty days, with the requirement that within that time the hospital should either discharge the patient or make application for a final order of certification.

(g) The Mental Hygiene Law should be amended to provide that the order of the judge shall certify a patient to the Department of Mental Hygiene, and not to a particular institution, and that the designation of the hospital to which the patient shall be admitted is to be determined by the Department.

CHAPTER VIII

ORGANIZATION OF THE DEPARTMENT OF MENTAL HYGIENE AND THE INSTITUTIONS OPERATED BY IT

1. The Department

From 1927 until May 1943, there had been two Commissioners, both former State hospital Superintendents. Since a certain degree of resistance on the part of the Superintendents to effective central control has been traditional, it was perhaps natural for a Commissioner coming from the ranks of the Superintendents to fail to exercise fully his powers of supervision over the institutions in the Department. The primary cause of the failure of the Department to keep pace with progress in the care of the mentally ill in New York in the last few years was this weakness of leadership at the top. This weakness was not because of lack of authority, for the Mental Hygiene Law confers wide administrative and supervisory powers on the Commissioner. It appears to have been because of the failure of the former Commissioner to exercise his legal powers, and assume his legal responsibilities with the necessary vigor.

The whole purpose of having a unified Department of Mental Hygiene, as contrasted with a group of separately operating institutions, was to get the supervision and guidance of a central office. The best result has not been accomplished in the past, with the consequence that those institutions with able Superintendents were well run, while other institutions with inadequate Superintendents were poorly run. There was no standardized policy of operation.

The conclusion is inescapable from the facts heretofore shown in this report, that driving power if it existed at all, has been dormant in the Department. A chief reason for the resulting inertia has been the failure of the Department to realize that twenty-six large institutions could not be left largely to themselves, in the expectation that they would solve their own problems and, uncoordinated, achieve satisfactory progress.

In the administration of the Commissioner's office there can be no substitute for an able, broad-gauged executive. The appointment of such an individual to this position must be at all times a prerequisite to the efficient operation of the Department.

There is no way in which the law can prescribe the appointment of an able executive. The choice of such a man is something which must be accomplished by the Governor who is then in office. However, it must be recognized that Governors in the past have had their hands tied to a certain extent in the appointment of a Commissioner by the requirement which was then in the law, that the Commissioner must be a person who had "at least five years' actual experience in the care and treatment of persons afflicted with mental disease in an institution for their care and treatment."[1]

[1] The law also provided that the Commissioner must be a physician who had at least ten years' experience in the actual practice of his profession.

With this limitation in the law it became, as a practical matter, almost impossible for the Governor to appoint to the office of Commissioner anybody who had not grown up in the New York State hospital system, and in actual practice both Commissioners preceding Dr. MacCurdy had been Superintendents of New York State hospitals. The Legislature in 1943 removed the restrictions on the appointive power of the Governor, thereby enabling the Governor to appoint to the position of Commissioner a person chosen primarily for his executive ability in hospital administration, rather than a person whose claim was based solely upon years of experience in the State hospital system. The Commission has been impressed by the energetic and imaginative manner in which the new Commissioner, Dr. Frederick MacCurdy, in the few months since his appointment, has tackled the administrative problems of the Department and has started a reorganization to correct some of the inefficiencies and inertia of the past.

While in the administration of a Department there is no substitute for an able executive, it is also true that an able executive must be surrounded by a staff which will enable him to perform the duties of his position. Under Section 11 of the Mental Hygiene Law, the Department has "the jurisdiction, supervision, and control" of all institutions in the Department to see that the purposes of such institutions are carried into effect. The Commissioner, with twenty-six institutions under his supervision, cannot carry out these duties alone. No matter how able a Commissioner might be, it is apparent that he should have attached to his office a staff of experts in the various functions of the institutions, who could inspect them in their varied aspects, and give to the Commissioner that guidance and advice which are prerequisites to the efficient operation of the Commissioner's office.

At no time in the past have arrangements been made for such a staff. This has been a fundamental defect in the organization of the Department. For example, there has been no Director of Nursing on the staff of the Commissioner to supervise and check the adequacy and efficiency of nursing care given in the institutions. There has been no Dietitian or Nutritionist on the staff of the Commissioner to supervise the adequacy of the diet in the different institutions, and this despite the fact that the Dpartment during a year serves over $8,000,000 worth of food. Although the institution farms have under cultivation some 12,000 acres, producing yearly at wholesale prices products valued at well over $1,000,000, there has been no Director of Farms on the staff of the Commissioner to supervise the operations of the farms by the institutions. Although the budget appropriation for personal services for a single year for the Department and its institutions is over $27,000,000, there is no provision for an expert on Personnel in the Department.

There has been in the Department a somewhat detached Bureau of Inspection consisting of four physicians; but the only inspections of the institutions in the past have been by short and infrequent visits of the Commissioner or Assistant Commissioner, and formerly

by quarterly visits from one of the physicians designated as Medical Inspectors. Since the war not even the quarterly visits have been made. The Medical Inspectors were chosen from those on the Civil Service Lists who were awaiting appointment, either as First Assistant Physicians at an institution or as Superintendent of an institution. They were looking forward to promotion in the Department and dependent largely for that promotion upon the support and cooperation of the very persons whose institutions they were inspecting. Under such a system it is apparent that the Medical Inspectors would be loath to criticize the operations of institutions, when they were dependent for their future career in the Department upon the good-will in part of those who were operating the institutions. Under such circumstances, it is not surprising that one of the Medical Inspectors stated on examination that during his entire period as Medical Inspector he had never found anything in any institution to criticize.

However, purely apart from this system of selecting medical Inspectors, it is also apparent that the functions of the Department are so diverse that it is impossible to concentrate the inspection function in only a medical man. For example, a proper inspection would necessitate a knowledge of nursing, dietitics, sanitary engineering, plant maintenance, accounting procedures, and operations of farms and of the schools maintained for mental defectives. To secure the proper type of inspection would require that the Commissioner have attached to his staff not a Medical Inspector, but persons competent to advise upon these various functions which are found in the institutions.

In the organization of the Department as a whole, there is also no clear-cut division of responsibility and authority. It is an axiom of sound administrative practice that executive authority, while centralized in one responsible head, must be delegated to others competent to exercise it, but must be so delegated that a subordinate responsible for one function does not assume responsibility for the functions assigned to others. This principle, however, has not been followed in the organizational set-up of the Department.

The Commission, therefore, recommends a reorganization of the office of the Commissioner, with a rearrangement of present functions and personnel and with authority to fill existing gaps. A chart of the proposed administrative organization of the Department appears on page 102 of this report. In this chart the rectangles indicate the functions which center in the Commissioner's office; the circles indicate the principal personnel involved in administering those functions. Subsidiary personnel, such as assistants, secretarial workers, etc. are omitted, since their numbers and assignments will be dependent upon the volume of work to be done.

In the proposed organization of the Department, the institutions will continue to be directly responsible to the Commissioner. The Commissioner will, however, have on his staff persons competent to carry out the executive and supervisory duties imposed upon him and to advise him and the institutions with reference thereto. It

is proposed that the Commissioner have in the Department two bureaus: (a) the Bureau of Professional Care and (b) the Bureau of Business Administration.

In the *Bureau of Professional Care* should center all of the supervision of professional service. The chief of this Bureau should be the Deputy Commissioner. Under the Deputy Commissioner, in the Bureau of Professional Care should be the following divisions:

(1) *Division of Medical Service.* This should be administered by an Assistant Commissioner. In this Division would fall the function of supervision and advice on all matters directly related to the medical care of patients, including clinical medicine, therapies, preventive measures, medical education, and research.

(2) *Division of Statistics.* This should be headed by a Director of Statistics, who should be an expert in vital statistics with special knowledge of those relating to mental disorders, and familiar with disease nomenclature and modern methods of classification, filing, and cataloguing of clinical records.

(3) *Division of Inspection.* This Division should be headed by an Assistant Commissioner or Chief Inspector. It should have the direct responsibility for the inspection of all licensed mental institutions in the State, and those institutions in the Department of Correction which the law provides should be inspected by the Department of Mental Hygiene. It should also have the duty of investigating and reporting upon complaints which might be sent to the Department. This Division should also attend to the duties of maintaining a careful inspection and observation of the methods for examining immigrants for mental disorders at the Port of New York, to the deportation or removal of alien and non-resident mentally ill, epileptics, and mental defectives. This Division should also have the duty of supervising the function of sanitary inspection for all the institutions, which function should be carried out by a qualified Sanitary Engineer in this Division.

(4) *Division of Nursing and Nursing Education.* This Division should be headed by a Director of Nursing, who should be a well qualified nurse administrator and educator. She should advise the Commissioner on matters relating to nursing in the institutions, and also act as an adviser to the Commissioner on problems of nursing education.

(5) *Division of Nutrition.* This Division should be administered by a Director of Nutrition, who should be a specially qualified Dietitian or Nutritionist, experienced in institutional food preparation and service, and who should advise the Commissioner on the adequacy of the food allowances, preparation, and service in the institutions. She should also be able to direct the education and research in the field of nutrition in the institutions.

(6) *Division of Social Service.* This Division should be under the direction of a Director of Social Service. It should have the duty of advising the Commissioner with reference to the social service work in the institutions of the Department, and the establishment of policies relating to clinics, family care, and parole.

(7) *Division of Schools.* This Division should be under the direction of a Director of Schools. It should have the duty of advising the Commissioner with reference to the educational programs, both academic and vocational, maintained by the Department in the State schools for mental defectives and in Craig Colony. The head of this Division should be a person who is qualified by training and experience in the special field of educational work for mental defectives.

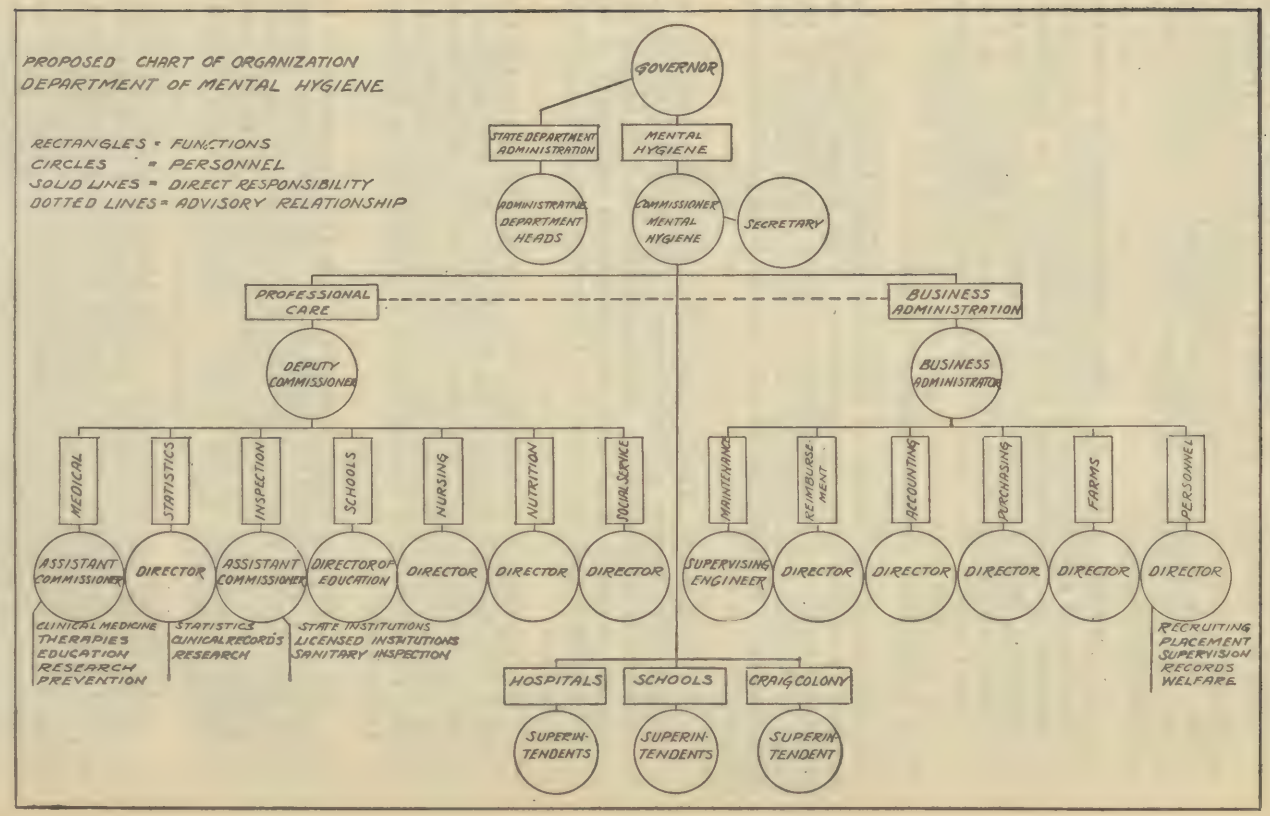
In addition to the Bureau of Professional Care, there should be the *Bureau of Business Administration.* This Bureau should be established under a trained business executive, who should have the status of Assistant Commissioner and be responsible directly to the Commissioner. This Bureau should include within it the following Divisions:

(1) *Division of Maintenance.* This Division should be in charge of a Director of Maintenance, who should be a competent supervising engineer. He should have the duty of inspecting the grounds, structures, and mechanical equipment of all institutions and advising the Commissioner with reference thereto.

(2) *Division of Purchases.* This Division should be headed by a Director of Purchases, who should have the duty of coordinating the purchase procedures of the institutions, and acting as a liaison officer between the Department of Mental Hygiene and the Division of Standards and Purchase of the Executive Department.

(3) *Division of Reimbursement.* This Division should be in charge of a Director of Reimbursement. He should have charge of collections of funds owing to the State from patients, legally liable relatives, or other persons legally liable. He should have direct supervision of the Special Agents in the Department charged with this duty.

(4) *Division of Accounting.* This Division should be under the direction of a Director of Accounting who should have the duty of coordinating the accounting procedures in the institutions throughout the State, and have direct supervision over the employees in the Commissioner's office charged with the preparation of necessary accounting and administrative statistical data for the Department, and act as liaison officer between the Department of Mental Hygiene and the Bureau of the Budget in the Department of Audit and Control.


PROPOSED CHART OF ORGANIZATION
DEPARTMENT OF MENTAL HYGIENE
RECTANGLES = FUNCTIONS
CIRCLES = PERSONNEL
SOLID LINES = DIRECT RESPONSIBILITY
DOTTED LINES = ADVISORY RELATIONSHIP
GOVERNOR
STATE DEPARTMENT ADMINISTRATION
MENTAL HYGIENE
ADMINISTRATIVE DEPARTMENT HEADS
COMMISSIONER MENTAL HYGIENE
SECRETARY
PROFESSIONAL CARE
BUSINESS ADMINISTRATION
DEPUTY COMMISSIONER
BUSINESS ADMINISTRATOR
MEDICAL
STATISTICS
INSPECTION
SCHOOLS
NURSING
NUTRITION
SOCIAL SERVICE
MAINTENANCE
REIMBURSEMENT
ACCOUNTING
PURCHASING
FARMS
PERSONNEL
ASSISTANT COMMISSIONER
DIRECTOR
ASSISTANT COMMISSIONER
DIRECTOR OF EDUCATION
DIRECTOR
DIRECTOR
DIRECTOR
SUPERVISING ENGINEER
DIRECTOR
DIRECTOR
DIRECTOR
DIRECTOR
DIRECTOR
CLINICAL MEDICINE
THERAPIES
EDUCATION
RESEARCH
PREVENTION
STATISTICS
CLINICAL RECORDS
RESEARCH
STATE INSTITUTIONS
LICENSED INSTITUTIONS
SANITARY INSPECTION
RECRUITING
PLACEMENT
SUPERVISION
RECORDS
WELFARE
HOSPITALS
SCHOOLS
CRAIG COLONY
SUPERINTENDENTS
SUPERINTENDENTS
SUPERINTENDENT

(5) *Division of Personnel.* This Division should be in charge of a Director of Personnel who should have extensive experience in personnel procurement and management. It should be his duty to act as an adviser to the Commissioner on matters of personnel procurement and employee relationships, and to act as liaison officer between the Department of Mental Hygiene and the Civil Service Commission. He should have no direct supervision over any institutional employees.

(6) *Division of Farms.* This Division should be under the direction of a Director of Farms, whose duty should be to inspect the farms operated by the institutions, and advise the Commissioner with reference to problems relating to such farms, and also to act as a liaison officer between the Department of Mental Hygiene and the Department of Agriculture.

While the heads of the foregoing Divisions would have the duty of inspecting the institutions, so far as their several functions would be concerned, they would have no direct administrative authority over the personnel in the institutions. Their functions would be those of inspection and guidance, and advising on the determination of broad policies to be adopted by the Commissioner. The results of their inspection would be made available to the Commissioner who, however, would be the sole person who would have the authority of direct administration over the institutions.

2. Institutions

The State mental institutions were established long before the State Department of Mental Hygiene existed. Each of the early institutions was entirely independent of the others, and was operated by a Board of Managers or Board of Governors. The institutions were relatively small. When Utica State Hospital was established one hundred years ago, it had a capacity of less than 300 patients. Over the years the size of the mental institutions has greatly increased, and the capacity is now rated in thousands instead of in hundreds. Pilgrim State Hospital, for example, has a rated capacity of 7,831, with nearly 10,000 patients in its care.

As has heretofore been pointed out in the chapter on Professional Care of Patients, the result of this tremendous growth in the institutions has been to emphasize the administrative functions of the Superintendent and the staff, to the detriment of the medical and clinical work. The consequence has been to place the emphasis upon the custodial rather than the curative features of the institutions.

Furthermore, these large institutions now are practically cities in themselves. An institution with from 5,000 to 10,000 patients, and numbering its employees in the thousands, and having annual budgets in some cases over $3,000,000, represents a business organization which is quite different from a small hospital. Nevertheless, the organization of the hospitals still carries over the concept of a relatively small hospital. For example, business operations are

centered in a man known as the Steward. The Steward in nearly every case has been a person who started in the Department in some subordinate capacity such as bookkeeper, timekeeper, or clerk. The Steward in most institutions has been given the supervision and determination of the diet and the preparation of foods, although in none of the institutions which have been surveyed has the Steward had any special training in this line.

The result has been that a large part of the administrative duties which should be placed upon a Business Manager of the institution, has fallen on the shoulders of the Superintendent; and the Superintendent has been more and more a business manager, rather than a medical head of the institution. The Superintendent, in turn, has had to pass on some of his administrative duties to his assistants, with the result that the Clinical Director has had to take over in many of the institutions, administrative and executive duties which do not properly belong in his sphere.

Furthermore, a great line of demarcation existed in the past, both in salary and perquisites, between the Superintendent and everybody else on the staff. The basic pay of a Superintendent today ranges from $8,500 to $10,500. The basic rate for First Assistant Physician, Clinical Director, and Steward is from $5,200 to $6,450.

The result has been that the highest position in the institution is reserved for an administrative officer, i.e., the Superintendent. The Superintendent should be a physician, but since his principal duties relate to the administration of a large institution, he should be preferably a man with a satisfactory record in the field of hospital administration. At the present time the law provides that the Superintendent must not only be a physician, but must also have had "at least five years' actual experience in an institution for the care and treatment of the insane." (Mental Hygiene Law, Sec. 33). The result of this limitation upon appointments, combined with the fact that the law provides that the Superintendent shall be in the competitive class of the civil service chosen by promotional examinations, has been to restrict the appointments of Superintendents to psychiatrists who have grown up in the State Hospital System. This system does not assure the ablest Superintendents. In selecting a Superintendent, the emphasis should be upon his executive and administrative ability, rather than upon his psychiatric knowledge or length of service in a State institution.

The Superintendent in each institution should have under him three well defined departments. These should be: the Department of Clinical Medicine, the Department of Professional Care, and the Department of Business Administration.

The Clinical Director should head the Department of Clinical Medicine. Under his direction and supervision should be Associate and Assistant Clinical Directors and the ward physicians.

If we are to retain physicians primarily interested in the cure of the mentally ill, we must make the position of Clinical Director in an institution a position approximately comparable to that of the

Superintendent, both in pay, emoluments, and distinction. This will mean that a physician will not find it necessary, after having devoted a large part of his life to psychiatric and medical work, to transfer to administrative work in order to reach the highest rewards in the institution.

Heading the Department of Professional Care should be a physician who should not necessarily be a psychiatrist. This should enable physicians of executive and administrative experience and ability to work up in the institution in the administrative phase of the institution's activities and, ultimately, to Superintendent.

Heading the Department of Business Administration in the institution should be the Business Manager. He should be a person of broad business education and background, competent to administer the business activities of an institution with a budget ranging up to $3,000,000 per year.

By such departmentalization of the institution there would be removed from the desk of the Superintendent the great mass of detail which, at the present time, makes him spend a large proportion of his time performing duties which should be delegated. It would also mean that, by differentiating between medical administration and clinical work, proper opportunity would be given for a competent and ambitious psychiatrist to advance in the clinical work of the institutions, and thereby put the emphasis on the curative rather than the custodial features of the institution.

While no fixed chart of organization can be laid down for the varying institutions in the Department, the above general description of a functional operation is one which, in the opinion of the Commission, would greatly improve the administration of the institutions and put the emphasis where it properly should be placed. A proposed Chart of Hospital Organization carrying out these features, which may have to be modified in certain institutions, will be found on page 107 of this report.

A chart of organization of itself is merely a blueprint of activities. The proper carrying out of the activities of the hospitals in the past has been impeded, not alone by lack of organization, but also by lack of competent personnel to carry out their functions. No organization will be effective unless competent people are chosen for the important positions. This matter is further discussed in the following chapter.

3. Boards of Visitors

Under Section 30 of the Mental Hygiene Law, each institution is to have a Board of Visitors, consisting of seven unpaid members, appointed by the Governor with the advice and consent of the Senate. The duties of the Board of Visitors are set forth in Section 32 of the law. The principal duties are:

(a) To take care of the general interests of the institution and see that its design is carried into effect;

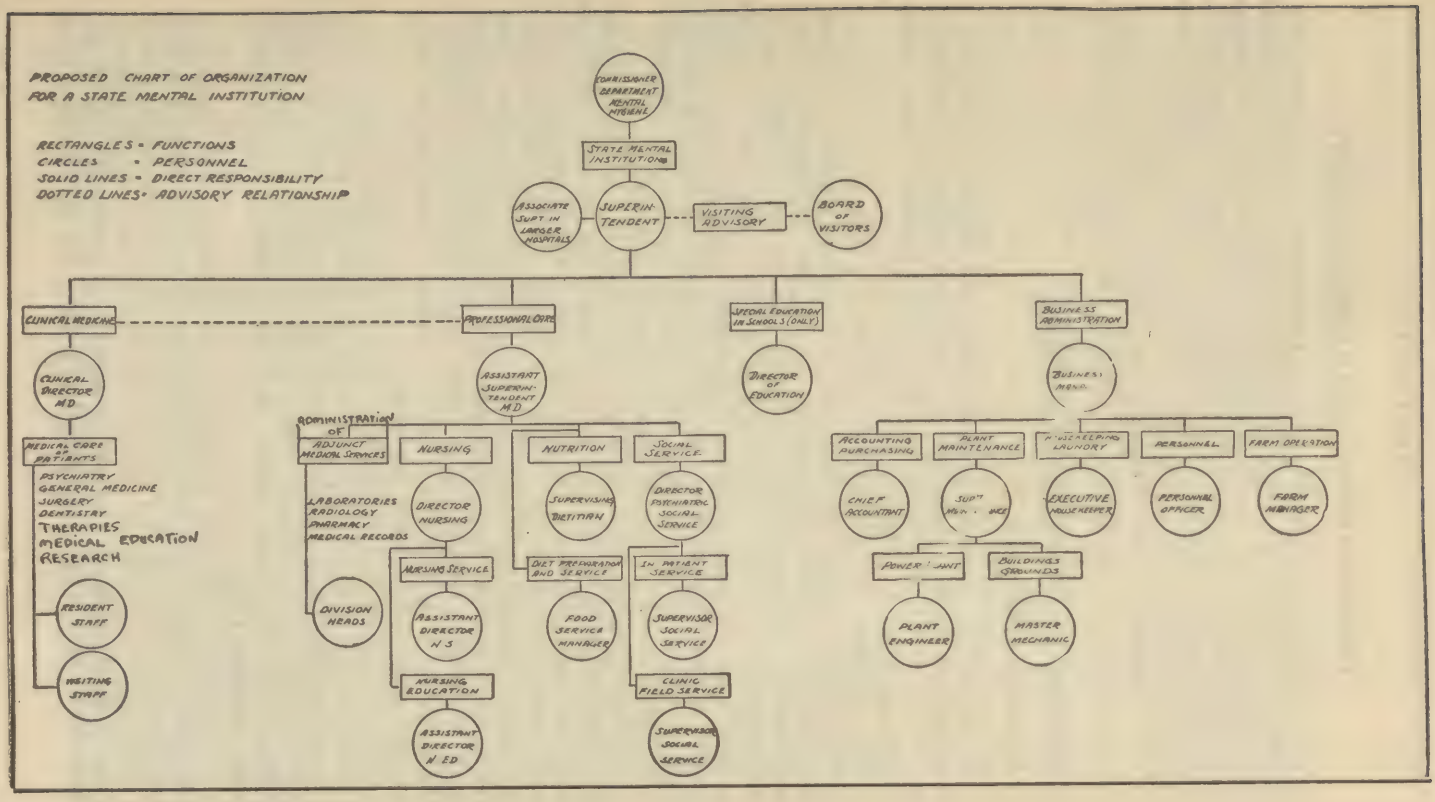
(b) to maintain an effective inspection of the institution with a visit at least once a month and the furnishing of a written report each month to the Governor and the Department as to the condition of the institution and its inmates; and

(c) to investigate, hear, and ascertain the truth of all charges made against the Superintendent of the institution.

The Board of Visitors may be able, intelligent, and constructive, or it may be lethargic, indifferent, and a "rubber stamp" for the Superintendent, depending upon the nature of the persons appointed to it. It is exceedingly necessary that the only appointments to such boards be of persons who will take a keen and independent interest in the institution. Boards composed of such members have been invaluable, not only as providing a lay inspection service but also because they furnish a public relations contact between the institutions and the community.

The Mental Hygiene Law is inconsistent, however, in that it imposes upon the Board of Visitors the duty of taking "care of the general interests of the institution" and seeing that "its design is carried into effect," while at the same time it gives the Board of Visitors no executive authority to enable it to meet this responsibility. This has led to much confusion in thinking on the part of the boards. Some believe that they are Boards of Managers and should run the institution; others think they have no powers and, therefore, no responsibilities.

The Boards of Visitors best perform their function when they act in a visitorial and public relations capacity. It is their duty to inspect the institutions thoroughly at periodic intervals and to report the results of their inspections to the Governor and the Commissioner. The management of the institutions should be the direct responsibility of the Superintendents and the Department. No division of this responsibility is desirable. To make the duties of the Boards of Visitors clear and to prevent the difficulties which now result from the ambiguities of the statute, it is recommended that Subdivision 1 of Section 32 of the Mental Hygiene Law be eliminated so that the Boards will not have imposed upon them duties which they have no authority to perform.


PROPOSED CHART OF ORGANIZATION
FOR A STATE MENTAL INSTITUTION
RECTANGLES = FUNCTIONS
CIRCLES = PERSONNEL
SOLID LINES = DIRECT RESPONSIBILITY
DOTTED LINES = ADVISORY RELATIONSHIP
COMMISSIONER DEPARTMENT MENTAL HYGIENE
STATE MENTAL INSTITUTION
ASSOCIATE SUPT IN LARGER HOSPITALS
SUPERINTENDENT
VISITING ADVISORY
BOARD OF VISITORS
CLINICAL MEDICINE
PROFESSIONAL CORPS
SPECIAL EDUCATION IN SCHOOLS (ONLY)
BUSINESS ADMINISTRATION
CLINICAL DIRECTOR M.D.
ASSISTANT SUPERINTENDENT M.D.
DIRECTOR OF EDUCATION
BUSINESS MGR.
MEDICAL CARE OF PATIENTS
PSYCHIATRY
GENERAL MEDICINE
SURGERY
DENTISTRY
THERAPIES
MEDICAL EDUCATION
RESEARCH
RESIDENT STAFF
VISITING STAFF
ADMINISTRATION OF ADJUNCT MEDICAL SERVICES
LABORATORIES
RADIOLOGY
PHARMACY
MEDICAL RECORDS
DIVISION HEADS
NURSING
DIRECTOR NURSING
NURSING SERVICE
ASSISTANT DIRECTOR N S
NURSING EDUCATION
ASSISTANT DIRECTOR N ED
NUTRITION
SUPERVISING DIETITIAN
DIET PREPARATION AND SERVICE
FOOD SERVICE MANAGER
SOCIAL SERVICE
DIRECTOR PSYCHIATRIC SOCIAL SERVICE
IN PATIENT SERVICE
SUPERVISOR SOCIAL SERVICE
CLINIC FIELD SERVICE
SUPERVISOR SOCIAL SERVICE
ACCOUNTING PURCHASING
CHIEF ACCOUNTANT
PLANT MAINTENANCE
SUPT MAIN. & ENG.
HOUSEKEEPING LAUNDRY
EXECUTIVE HOUSEKEEPER
PERSONNEL
PERSONNEL OFFICER
FARM OPERATION
FARM MANAGER
POWER PLANT
PLANT ENGINEER
BUILDINGS GROUNDS
MASTER MECHANIC

CHAPTER IX

THE PERSONNEL OF THE DEPARTMENT

The efficiency of operation of this Department is in direct relationship to the quality of the personnel employed by it. A hospital or school is an institution peculiarly dependent for its effectiveness upon the persons who work in it and who conduct its operations. The standard of professional care can rise no higher than the men and women who direct and conduct it in its various aspects.

The Commission has considered the problem of personnel from the standpoint of adequacy in numbers and adequacy in quality.

1. Adequacy in Numbers of the Personnel

(a) Budget Allowances

On December 1, 1943 the Department had appropriations for a personnel of 21,814 individuals. The appropriation for personal service in the Department for the twelve months' fiscal period beginning April 1, 1943 was $27,351,715.

The provision for physicians and ward personnel in the past years seems to have been adequate. The quota in 1943 for physicians in the hospitals was approximately one physician for each one hundred and seventy-five patients. As has been pointed out in the chapter on Professional Care of Patients, the need is not so much for an increased number of physicians as for a better organization of the clinical work, including a visiting medical service, and a removal of the inertia with respect to clinical psychiatric work which seems to exist in many of the institutions.

In the section on Nursing Care in that chapter, it is also pointed out that provision of one nurse or attendant for each 6.75 patients is an adequate allowance provided that at least 24 per cent of the ward personnel consists of registered nurses. The 1943 allowance for ward personnel in the hospitals approximated that ratio. However, out of a total ward personnel of 11,144, only 13.9 per cent were registered nurses. The need is, therefore, not a greater allowance for ward personnel, but a greater proportion of registered nurses in that ward personnel.

When we turn to the problem of dietitians, occupational therapists, and psychiatric social workers, we find, however, that suitable allowances have not been made in the past. In 1943 there were provided for these positions in all institutions dietitians 27, occupational therapists, aides, and instructors 317, psychiatric social workers 151.

To provide a suitable number of dietitians would require at least one dietitian for each 1,000 patients in the State hospitals and the State schools, or a total of approximately ninety dietitians.

As is pointed out in the chapter on Professional Care of Patients, there is need for twice as many occupational therapists, aides, and instructors as are now provided and need for an increase of at

least one hundred twenty psychiatric social workers in the hospitals and in the schools.

(b) Shortages Incident to the War

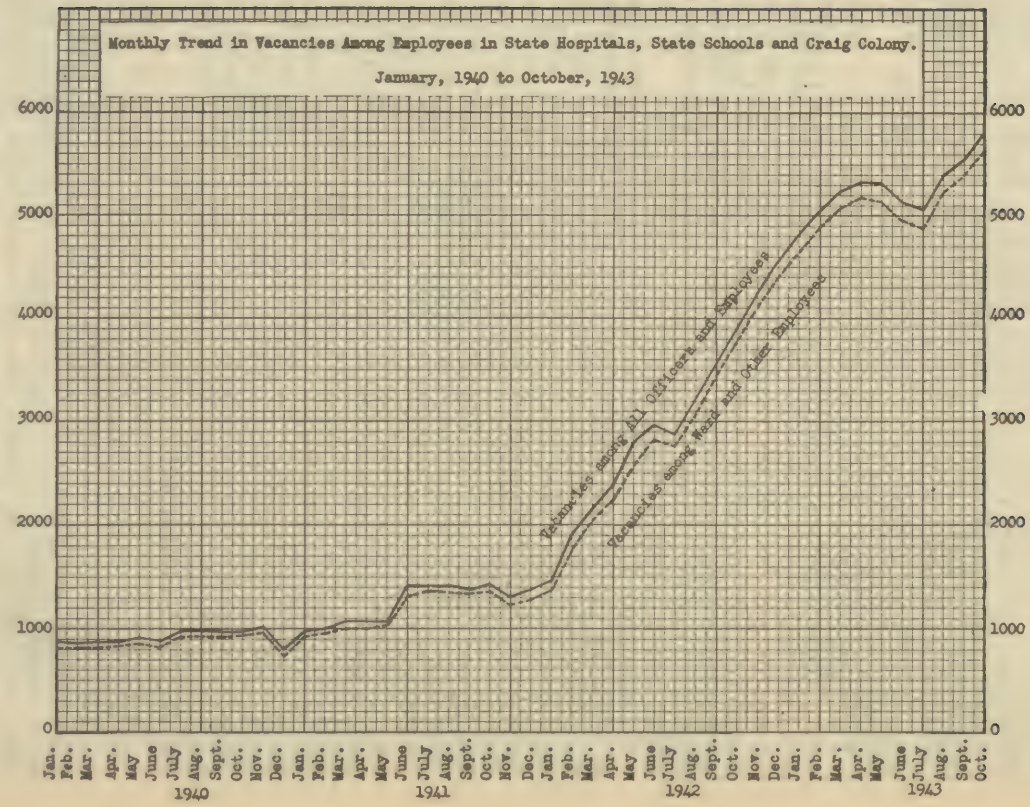
The mere fact that the Legislature has appropriated sufficient funds does not secure an adequate personnel in these days. The war has made a very serious drain upon the employees in this Department. As has heretofore been pointed out, the over-all shortages of employees in the various categories on October 1, 1943 were as follows: physicians 31 per cent, ward employees 32 per cent, and other employees 17 per cent.

The above figures, alarming as they are, do not tell the whole story. Willard State Hospital has lost 59 per cent of its medical staff and St. Lawrence has lost 56 per cent. Wassaic State School has lost 50 per cent of its ward personnel and Gowanda State Hospital 49 per cent of its ward personnel. Pilgrim State Hospital has lost 46 per cent of its ward employees and 32 per cent of other employees. Craig Colony for epileptics has a shortage of 43 per cent in its ward employees.

Commissioner MacCurdy has taken steps to stop further losses as far as he can but the best he can hope for is that the institutions may hold their own until after the employment shortage eases up. Rulings have been secured designating the work in these hospitals as an essential occupation so far as the draft status is concerned. With the assistance of the United States Employment Service, the Department instituted last year a recruiting drive to secure ward employees from Virginia, West Virginia, Tennessee, and North Carolina. Many of the other states refused clearance to permit solicitation of employees in those states. As a result of the employment drive up to October 15, 1943, 638 applicants were interviewed, 411 were hired, and 333 of these reported for duty. Out of the 333, 134 had resigned prior to October 15, 1943. In September a plan was proposed which, with the help of the United States Employment Service, was designed to secure people available in this State. This started on October 1, 1943 and during that month resulted in the employment of thirty-five persons.

There have been two reversals in the trend of increasing vacancies in these institutions since November 1941 as shown on the chart on page 110. The first change came when an increase in salary of $100 was given in June 1942. The second occurred during the recruiting efforts in the Southern States during May to July 1943. Nevertheless, the general trend has been upward and is still upward. Were it not for the fact that many of the present employees work overtime and that overtime pay is allowed to them for this service under an amendment to the law adopted in the 1943 legislative session, the situation of most of the institutions would be precarious indeed.

The shortages in personnel at the several institutions as of October 1, 1943 are set forth in the following charts:


Monthly Trend in Vacancies Among Employees in State Hospitals, State Schools and Craig Colony.
January, 1940 to October, 1943
Vacancies among All Officers and Employees
Vacancies among Ward and Other Employees
6000
5000
4000
3000
2000
1000
0
Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.
1940
Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.
1941
Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.
1942
Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct.
1943

State Institutions	Medical Officers		Ward Employees		Other Employees	
	In Service	Vacancies	In Service	Vacancies	In Service	Vacancies
State Hospitals:						
Binghamton	17	1	386	28	256	17
Brooklyn	31	.....	647	.....	235	42
Buffalo	10	6	187	119	215	23
Central Islip	26	19	607	469	380	110
Creedmoor	19	8	445	209	297	51
Gowanda	10	5	203	198	198	36
Harlem Valley	15	10	449	211	239	62
Hudson River	19	9	491	178	367	49
Kings Park	24	17	603	326	375	137
Manhattan	20	2	401	147	318	50
Marcy	11	4	266	100	213	56
Middletown	10	11	417	102	228	26
Pilgrim	34	20	694	590	378	184
Psychiatric Institute and Hospital	18	2	63	24	151	13
Rochester	13	5	352	141	168	55
Rockland	31	9	579	361	404	72
St. Lawrence	7	9	285	36	235	12
Syracuse Psychopathic Hospital	3	1	33	15	19	8
Utica	9	4	203	71	200	33
Willard	7	10	263	170	247	61
Total	334	152	7,574	3,495	5,123	1,097
State Schools for Mental Defectives:						
Letchworth Village	10	6	400	110	222	33
Newark	8	1	239	92	166	18
Rome	7	7	366	142	194	51
Syracuse	5	1	155	6	131	6
Wassaic	11	3	290	292	187	51
Total	41	18	1,450	642	900	159
Craig Colony for Epileptics	9	4	180	136	186	42
Grand Total	384	174	9,204	4,273	6,209	1,298
Total authorized positions	558		13,477		7,507	
Percentage vacancies	31%		32%		17%	

2. Adequacy in Quality of the Personnel

The problem of this Department, as of any other organization, is to attract the ablest and best qualified persons for the positions to be filled. The conditions which have existed in this Department for years and which have been criticized in this report have been, in prewar days, due only to a minor degree to a lack of personnel. They were due in part also to improper organization and supervision which has been discussed in the preceding chapter. They were the result principally of the failure to secure personnel adequately capable of meeting the responsibilities entrusted to them.

There are three types of positions where this inadequacy is marked: (a) the supervisory professional positions, (b) the supervisory business positions, and (c) the ward personnel. The following are, in the opinion of the Commission, the reasons for this inadequacy and the Commission's recommendations with reference thereto:

(a) The Supervisory Professional Positions[1]

In this classification are such persons as the Superintendent, Associate Superintendent, Clinical Director, Director of Education, Assistant Superintendent, Director of Laboratories, Director of Nursing, Supervising Dietitian, and Director of Psychiatric Social Service.

At the present time these positions, as well as all other positions in the Department, can be filled only by promotional examinations from among those in a lower grade in the Department. The result is that no new blood can, as a practical matter, enter the Department except in the lowest grade. As was pointed out in the chapter on Professional Care of Patients, the present system makes it impossible to secure experienced men from outside of the Department. An able, alert man who has left the Department to gain a variety of experience, cannot thereafter reenter the Department except at the lowest position. Thus to a great extent such men are winnowed out of the system forever, and the Department has, as a practical matter, been unable to secure solely from the ranks of those who have remained in the Department, men capable and experienced enough in later years to supervise the operations of the vast institutions of which this Department is composed.

The benefits of the civil service system, as it affects security, freedom from political interference, and retirement rights, are obvious and should be continued. In choosing men of professional standing for positions of authority in the institutions, it is, however, highly undesirable to limit the civil service examinations to those already in the Department. To require that promotions always be made from those in the Department not alone limits the choice but leads to a form of departmental inbreeding which stifles progress and deadens initiative.

The patients in the institutions are entitled to have the best medical personnel, to the extent that these people are available, in positions of authority. If they are available in lower ranks in the institutions, they should be chosen from these lower ranks, but there is no way of determining whether the ablest men are available unless the examinations for the positions are placed in the open competitive class.

Under Section 16 of the Civil Service Law provision is made for the Civil Service Commission to grant an open competitive examination whenever the appointing officer requests it, stating the reason why it is "impracticable" to fill the vacancy by promotion. It might be difficult to say that it is "impracticable" to fill positions among the professional staffs of these hospitals by promotions from the lower grade in the same service. It certainly is true, however, that it is impossible to determine whether the ablest men are being secured and impossible to secure any new blood from the outside for these positions without an open competitive examination. It is, therefore, the recommendation of

[1] Titles taken from Organization Chart on page 107.

this Commission, and considered by it to be a prerequisite to any substantial improvement in conditions in these institutions, that steps be taken to provide that all the above mentioned positions in the supervisory professional group shall be filled by open competitive civil service examinations. All positions other than those mentioned should, in the opinion of the Commission, remain in the purely competitive class of the civil service and promotions therein should be made from the lower ranks in the same service.

Unless this change is made in the law and provision made to secure new blood in the institutions through open competitive examinations, no hope can be held out for substantial progress in the Department. It is well recognized that for some time highest appointing officers have felt that while there were civil service lists in existence for certain of the supervisory positions, there was no person upon those lists adequately qualified for the appointment. When the war is over, numerous physicians will return from the war service with experience in the administration of large military hospitals and large psychiatric pavilions. They will have had both executive training and medical training. Some of them may have previously been in the Department of Mental Hygiene and others not. To secure the ablest men for the supervisory positions, the examinations in the future should be open to such men as these and men who have gained wide experience in other institutions, so that when the appointment is made the people may be assured that the person chosen for the position is not only the ablest of the few but the ablest of all those who chose to compete for the position.

(b) The Supervisory Business Positions

The supervisory business position in the institutions is now known as that of the Steward. The business management of one of these institutions needs a person of wide business training and experience. The Steward has the overseeing of power plants, building maintenance, kitchens, grounds, gardens, farms, laundries, machine shops, and a fire department. He must arrange for the purchase of supplies for thousands of people, the maintenance and repair of many buildings, the building of roads, the supervision of large groups of employees, and for keeping proper accounting records.

Because of the fact that appointments to this position have always been filled by promotions from lower ranks of the Department, the Steward has usually been somebody who started life as a clerk in one of the institutions. He rarely has had that training or breadth of experiences necessary to qualify him properly for so important a position as that which he will ultimately fill.

Here again for the same reasons mentioned under "Supervisory Professional Positions," it is desirable that appointment to the position of Business Manager be filled by open competitive examinations and the requirements for this position both in education

and experience increased over what they have been in the past. Only in this way will the positions be filled in the future with men of the breadth of vision required.

(c) The Ward Personnel

The attendants are the largest group of employees in the Department. Their payroll scale, including maintenance, runs from $1,200 to $1,600 per year. They are usually untrained and unskilled.

There is no way of determining by an examination what man or what woman would make a good attendant. The qualities of personality, rather than the qualities of education or even intelligence, are the ones which will be largely determinative of the ability of an attendant to meet the demands of the position.

In the past, personnel for the attendant positions was largely chosen from people who lived in the community surrounding the institution. The Superintendent and other officers had an opportunity to have a personal interview with the attendant before he was hired and to dispense with his services if, after a trial period, he seemed temperamentally unfit.

On January 1, 1941, the position of attendant was placed in the competitive class of the civil service. The minimum requirements for the position were "an ability to speak, read, and write the English language with facility; good physical condition." When a candidate passed an examination indicating that he was able to fulfill these simple requirements, he was then placed on a civil service list. No means were taken to check his references or to determine how well his previous work had been performed. In fact, he might even have had a criminal record which was not discovered before he was placed in a position.

The result was that attendants were chosen not after a personal interview but picked from the top of a list. An individual might be able to read and write the English language and to be in good physical condition but if he were nervous or excitable, for example, he would be incapable of being a competent attendant even though there would be no basis from a legal standpoint for removing him upon charges under the civil service regulations. The result was a steady deterioration in the quality of the attendant personnel which had become quite marked even before the present shortage of manpower.

In March 1942, the Civil Service Commission finally approved appointments of attendants under Rule VIII–10 of the Civil Service Rules permitting the appointing officer to make the selection and give the examination. Recently, the Civil Service Commission, with the approval of the Governor, has amended its rules to provide for a nine months' probationary period. This is a highly desirable change. The benefits of the civil service system are obvious but the application of any such system to positions such as attendants without a proper preliminary trial period, tends to

freeze into the Department persons totally unfitted for their duties. This problem has been discussed not alone with the Superintendents and members of the Boards of Visitors, but also with representatives of the Employees' Association and the feeling is unanimous that applicants for the position of attendant should be chosen only after a personal interview with those who know the needs of the institutions.

There has been great difficulty in securing competent attendants. This position has been a dead-end job. The title of attendant in a mental institution carries with it no prestige and is frequently considered a detriment rather than a help in applying later for a position outside the institution. In order to attract better types of men and women for this work, an opportunity must be given for some education and advancement in the job so that persons will enter it feeling that it is a step toward improving their position in life. An attendant who considers his position as comparable with that of a keeper in a State prison will never be a useful person in providing a program of effective care for the patients in his charge.

In order to secure applicants for this position who are better qualified and who will take more interest in their work, it is recommended that courses be established by the Department which will enable the attendant to qualify for a license as a practical nurse. This will give an opportunity for advancement and semi-professional standing to those who complete the course and carry on their duties satisfactorily. It is also recommended that the title of attendant be eliminated and that the ward personnel in the future consist of the following: registered nurses, licensed practical nurses, senior ward aides and ward aides.

The title of Senior Ward Aide is proposed to take care of the numerous very excellent attendants who may not be eligible to secure a license as practical nurse. Senior ward aides and the practical nurses would perform such nursing duties as have heretofore been largely performed by attendants. Progress to the position of practical nurse should be open both to ward aides and senior ward aides.

Attention should also be given to the salary scale for the registered nurses. At the present time, a registered nurse in one of these hospitals has a salary scale of from $1,400 to $1,900 which is barely above that of the attendant and less than that of a staff attendant for whom no professional qualifications are required.

3. Morale of Employees

On October 1, 1943, the Feld-Hamilton Law (Civil Service Law, Art. 3) became applicable to the Department of Mental Hygiene. This was an effort to make the salaries for positions in this Department comparable with the salaries in other departments. The application of this law to the Department necessitated the reclassification of all employees by the Civil Service Classification Com-

mission and an increase in salary to offset a charge for maintenance. The result has been that few of the employees have had an actual increase in cash salaries. No one received less cash salary than was received before.

The operation of the law has, however, had an unsettling effect. Certain positions have lost titles indicating particular skills of which the employees are proud. Certain institutions, for example, have found carpenters transformed by reclassification into maintenance men, a deep affront to the craftman's pride of the carpenter. In other instances, titles have not been set in relation to technical training. The Food Service Manager, for instance, is required to have a high school education while the Senior Dietitian, who is rated lower in the classification list, must be a college graduate. With the passage of time and adjustments which may be expected from appeals now pending, it is hoped that some of the unsettling effect of the application of this law to this Department will be eased.

The provisions of this law which now permit certain officers and employees to live outside the institutions and to receive cash in lieu of maintenance is a step decidedly in the right direction. While a certain number of employees must, of course, remain in residence in the institution to be available for emergencies, the more officers and employees who can be allowed to live outside the institution in a normal family life, the more stable and happy will be the personnel of the institution.

There is a constant complaint among the employees of the Department as to the quality and lack of variety in the food furnished them. Since the employees must now pay for their maintenance, it is the belief of the Commission that it would be desirable to try the experiment in some institutions of establishing employee-cooperative cafeterias to be managed by the Employees' Association and to provide food for them at cost. This would enable a variety of food to be furnished and would do much to increase the morale of the employees. Such cooperatives have been found to be particularly successful in some of the government office buildings and war plants.

CHAPTER X

SUMMARY OF PRINCIPAL RECOMMENDATIONS AND ACTION TAKEN OR PROPOSED IN CONNECTION THEREWITH

The recommendations of the Commission designed to improve conditions in the Department of Mental Hygiene, with the reasons for such recommendations, are set forth in the report. They have been made with one purpose in mind, namely to help the patient directly through better care and indirectly by greater efficiency in the operation of the Department.

The primary defect in this Department until recently has been lack of adequate executive direction from the top designed to make the institutions operate with adequate efficiency and to put the emphasis on the curative rather than custodial care of the patients. The new point of view brought to the Department by Dr. MacCurdy and the initiative and energy displayed by him in meeting the manifold problems of the institutions indicates that this primary problem of having a competent executive in charge of the Department has been met.

However, there are a number of other defects shown in this report which have needed, and some of which still need, remedial action.

The Commission has not been satisfied merely to wait until a report could be printed embodying its recommendations. Throughout the past few months it has worked with Commissioner MacCurdy, the representatives of the Executive Department and members of the Legislature with a view to the taking of steps designed to correct, as far as is possible at the present time, certain of the outstanding defects which it has found in this Department. There have, therefore, already been put into effect certain changes in this Department and certain legislation has been introduced with a view toward correcting other conditions set forth in the report. Certain of the other recommendations made by the Commission cannot be put into effect without further study by the Department or until after the war emergency has passed.

The following is a summary of the principal recommendations of this Commission as set forth in this report, together with a statement of the action taken or proposed to carry such recommendations into effect:

1. Recommendations as to Which Remedial Action Has Recently Been Taken

(a) The Commission has pointed out that in order that the Commissioner of Mental Hygiene may properly administer the Department it is necessary that he be provided with a staff of division heads to inspect and advise him with reference to the different functions of the institutions directed by him. The new

budget has made provision to furnish him with substantially all the division heads recommended by this Commission. This should immeasurably increase the efficiency of the Commissioner's office.

(b) A revision of the classification of the ward personnel substantially as recommended by this Commission is being put into effect. Plans are now being made to open schools in the Department for training practical nurses so that the position of attendant will no longer be a dead-end job but will provide opportunity for advancement and a type of professional training. These changes should result in securing more and better ward employees, especially when the present manpower shortage eases up.

(c) Provision has been made in the new budget for an increased number of dietitians for the institutions and for a substantial increase in the appropriation for food for patients and employees.

(d) A central clinic for medical and social service supervision of patients in the New York City area has recently been set up. An extension of this program so that the parole clinics will operate by geographical areas, rather than by hospitals, in the balance of the State is desirable so as to avoid duplication of effort and unnecessary travel.

(e) The Commission has recommended that medical and surgical interns and residents be provided in each institution. The new budget makes such appointments possible.

(f) The Commission has recommended as a principal step to reduce the load on the State Hospitals a study looking forward to the establishment by the State, counties and municipalities of an integrated program for the care of the indigent aged including those with mental deterioration due to age. This is one of the matters which will be considered and studied by the Legislative Commission recently appointed on the recommendation of Governor Dewey to work out a coordinated program for the welfare and social service activities of the State.

2. Recommendations Requiring Legislative Action as to Which Bills Have Been Introduced

(a) Changes in Admission and Discharge Procedure.

(1) A change of the word "commitment" to "certification."

(2) A change of the word "parole" to "convalescent status."

(3) A change of the word "insane" to "mentally ill" wherever that word appears in the statute or the procedural forms.

(4) Increase of observation period to sixty days.

(5) Provision for a court to certify a patient for a period of preliminary observation.

(6) Certification of the patient to the Department rather than to a particular institution.

(7) Provision that the Department is to be notified of all applications for commitment to State hospitals with the right to appear and present reasons in opposition to the commitment.

(8) Provision for the finger-printing of all patients.

(b) Clarification of the Duties and Responsibilities of Boards of Visitors

(1) Elimination of subdivision 1 of Section 32 of the Mental Hygiene Law so the Boards will not have imposed upon them duties which they have no authority to perform.

(c) Reimbursement for Patient Care

(1) Authorization to the Commissioner to fix a standard rate for a patient's care.
(2) Allowance for appeal by a legally liable relative from the rate fixed by the Commissioner with provision that his determination, subject to right of such appeal, shall be a final determination of the relative's obligation to pay the rate so fixed.
(3) Provision for a penalty for wilfully false or inadequate information as to resources or income of legally liable relatives.

Legislation to carry into effect the foregoing recommendations of this Commission as well as to make certain other technical changes, approved by this Commission, in the Mental Hygiene Law has been introduced in the Legislature.

3. Further Recommendations of This Commission for Future Action

(a) Changes in the Departmental Organization and Procedure

(1) Reorganization of the hospitals to increase the emphasis on clinical medicine by providing in each hospital a Department of Clinical Medicine, a Department of Professional care, and a Department of Business Administration.
(2) Elevation of the Clinical Director in each institution to a position approximately commensurate in salary and perquisites with that of the Superintendent.
(3) Appointment to positions as heads of departments or services in the institutions by open competitive civil service examination not restricted to promotional examinations from those already in the Department.
(4) Examination for Superintendents and Associate or Assistant Superintendents to be open to those physicians with experience in hospital administration and not restricted solely to those whose experience is in hospitals for the mentally ill.
(5) Establishment at each institution of staffs of visiting physicians to conduct regular services in their specialties of medical practice.
(6) Segregation of the teachable mental defectives in separate State schools and transfer of the unteachable mental defectives from these schools to the other schools.
(7) Provision for an increased staff of psychiatric social workers and an increased staff of occupational therapists.

(8) Provision, as soon as they are available, for a larger proportion of registered nurses in the over-all allowance of ward personnel.

(9) Establishment on a trial basis of employees' cooperative cafeterias in certain of the institutions.

(10) Periodic review of all cases to ascertain eligibility for parole.

(11) Central supervision and direction of an increased program for family care.

(12) Utilization of the colony plan for certain types of State hospital patients.

(13) Establishment in local voluntary and municipal hospitals of psychiatric units and clinics, with State aid if necessary.

(b) Education and Research

(1) Opening of the facilities of the State hospitals for education in psychiatry to medical students and practicing physicians.

(2) Utilization of the Psychiatric Institute to provide teaching facilities for the staffs of the institutions and for the supervision and coordination of research in the institutions; making opportunities available to members of the staffs of the institutions to become members of the staff of the Institute for limited periods of time for postgraduate education and research.

(3) Discontinuance of Syracuse Psychopathic Hospital or, in the alternative, utilization of its facilities for the specialized treatment of, and research into, certain types of mental illness for which facilities are not available in the State hospitals.

(4) Establishment of a Departmental school of nursing with authority to supervise and direct all nursing education in the different institutions; preclinical nurse training to be conducted at certain regional schools and the balance of the work, except for a period of affiliation, to be done at the various State hospitals with a teaching program directed and supervised from a central source.

(5) Establishment of a Departmental school for the training of practical nurses with branches in certain of the State hospitals but all directed and supervised from a central source.

(c) Physical Plants

(1) Establishment, as part of a postwar planning program, of a hospital or hospitals sufficient to accommodate approximately 4,000 tuberculous mentally ill.

(2) Appropriation of a maintenance fund to the Department to spend currently where such expenditures are most needed to maintain buildings and equipment in proper condition rather than the appropriation of such amounts to the separate institutions.

(3) Adoption of the recommendations of the Department of Health with reference to dairy herds and handling of milk.

(4) Reconstruction or rebuilding of certain buildings in the older institutions as part of a postwar planning program; construc-

tion in certain institutions of additional reception units and units for bed patients; erection or reconstruction of buildings at Craig Colony to enable proper care to be taken of the deteriorated patients. Certain temporary reconstruction has already been started at Craig Colony.

(5) Survey of fire hazards in all institutions by the National Board of Fire Underwriters.

(6) Provision for exercise areas for ambulatory patients in as many institutions as possible.

(7) Relocation of all distant colonies to sites more nearly adjacent to the parent schools. One such colony has already been transferred by Commissioner MacCurdy.

(d) Reimbursement for Patient Care

(1) Provision for billing of all amounts for patient care from a central office rather than from each institution.

(2) Employment of investigators to check on the information given by relatives as to their financial resources and income.

(3) Utilization of the facilities of the Family Court in New York City to enforce orders for the payment of amounts due for patient care.

(4) Review of all veterans' cases to determine which are "service-connected."

(e) Accounting

(1) Acceptance of cash for patients' luxury funds only at the business office of each institution and the issuance of formal receipts therefor.

(2) Installation of uniform accounting systems for all community stores with periodic audits thereof.

(3) Responsibility of the business office to be established for all occupational therapy receipts.

(4) Issuance of a ruling prohibiting the use of colony funds for purposes other than actual expenditures made on behalf of patients and for reimbursement for maintenance of the patients.

(5) Maintenance of perpetual inventory records of the institutions both as to the quantity and value of supplies received and disbursed.

(6) Restoration of the work of preparing pay-rolls to the individual institutions.

(7) Abolition of the requirement of a quarterly estimate and substitution therefor of an encumbrance ledger.

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